CHILDRENS DIABETES AND ENDOCRINOLOGY

REGISTRATION FORM

DATE:_____ **PLEASE PRINT**

Patient Name:_____
First Middle Last

Address:_____
Street City State Zip

Home Phone (____)_____ Work(___)_____ Cell(___)_____

Female:_____Male:_____Age:_____Birthdate_____

PATIENT'S Social Security # (Mandatory): _____/_____/_____

If Student, Name Of School:_____ Grade:_____

E-mail Address_____

INSURANCE INFORMATION

Primary Insurance:_____ Policy / ID#_____

Group#:_____Specialist Co-Pay_____

Policyholder Name:_____DOB:_____SSN:_____

Secondary Insurance:_____ Policy / ID#_____

Group#:_____Specialist Co-Pay_____

Policyholder Name:_____DOB:_____SSN:_____

NAME OF PARENTS/GUARDIANS RESPONSIBLE FOR ABOVE CHILD:

Mother:_____ DOB:_____ SSN:_____

Father:_____ DOB:_____ SSN:_____

Mother Occupation:_____ Employer:_____

Father Occupation: _____ Employer:_____

NAME & ADDRESS OF CLOSEST RELATIVE IN CASE OF EMERGENCY:

Name:_____ Relation:_____

Address:_____City_____State_____Zip_____

Phone: (___)_____ Cell (___)_____

PCP:_____PCP Phone (___)_____

Referred By:_____Phone (___)_____

Does Patient Have Any Allergies? Yes_____ No_____ To What?_____

INSURANCE AUTHORIZATION AND ASSIGNMENT: I hereby authorize Children's Diabetes & Endocrinology to furnish information to insurance carriers concerning my illness and treatments, and hereby assign to the physician, all payments for medical services rendered to the patient listed above. I understand that I am ultimately responsible for any amounts not covered by my Insurance. I also, understand that I will be responsible for any and all costs associated with my account if it is referred to an outside collection agency. Revised as of **04/20/2016**

DATE: _____ SIGNATURE:_____