Patient Registration Form

Patient Information

Patient's Name: _____ D. O. B. _____ Sex ___
First Middle Last Suffix

Address_____ City_____ State _____ Zip: _____

Insurance Information

Insured's Name _____ D. O. B. _____ Sex____ SSN _____

Address _____ Ph #_____

City_____ State ____ Zip: _____ Relation to Patient_____

Insurance Co._____ Ph #_____

Policy #_____ Group Name _____ Gr. #_____

Employer _____ Employer's Ph #_____

Guarantor Information

Guarantor's Name _____ D. O. B. _____ Sex ____ SSN _____

Address _____ Relation to patient _____

City_____ State ____ Zip: _____ Driver's license # _____

Phone: Home _____ Cell_____ Work_____ Email _____

Employer _____ Employer's Ph #_____

Family Information

Father's Name_____ D. O. B. _____ SSN _____

Address _____

City_____ State ____ Zip: _____ Ph: Home _____ Cell_____

Employer_____ Work _____ Email _____

Mother's Name_____ D. O. B. _____ SSN _____

Address _____

City_____ State ____ Zip: _____ Ph: Home _____ Cell_____

Employer_____ Work _____ Email _____

Siblings' names:

_____ Age ____ M F

_____ Age ____ M F

_____ Age ____ M F

_____ Age ____ M F

_____ Age ____ M F

_____ Age ____ M F

_____ Age ____ M F

_____ Age ____ M F

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Emergency Contact Information
Name _____ Home Ph _____ Relation to patient_____ Cell Phone _____

How did you choose Mid City Pediatrics? _____

Which doctor would you like to see? □ Robert Haynie □ Scott Ritch □ Angela Cush-John

□ David Pace □ Sharye Atchison □ Emily Hobson □ Jennifer Cockrell

Name of previous doctor _____ Phone number_____

Address _____ City_____ State _____ Zip _____

If **you wish for past medical records to be transferred to our office, please ask the receptionist for a medical record request form**

Please read and sign all statements:

I am a parent or legal guardian of _____ (Name of patient)

I understand that services provided in this office require payment and that I am responsible for that payment whether I maintain insurance coverage or not. I understand that payment is due from me until insurance payments are received and the entire debt is satisfied. If collection services are necessary, I will pay all costs including attorney fees.

Date _____ Signed _____

In the event of an emergency and I (parent/guardian) am not immediately available, I authorize any of the physicians or nurses in our practice to perform whatever emergency treatment or procedure that he or she deems necessary.

Date _____ Signed _____

I authorize Mid City Pediatrics to release medical records pertaining to my child to individuals or institutions requiring them for treatment or services including but not limited to the following: Hospitals, other physicians, insurance companies, and schools.

Date _____ Signed _____

I have received, read, and understand Mid City Pediatrics' Notice of Privacy Practices.

Date _____ Signed _____

I have received, read, and understand Mid City Pediatrics' Vaccine Policy.