GREEN ROAD PEDIATRICS INC
Pediatric & Adolescent Medicine

PATIENT REGISTRATION FORM

Children's Names		Birthday	School
_____	M / F	___/___/___	_____
_____	M / F	___/___/___	_____
_____	M / F	___/___/___	_____
_____	M / F	___/___/___	_____
_____	M / F	___/___/___	_____

BEST phone number to contact you: (_____) _____

SECONDARY phone: (_____) _____ PATIENT'S cell: (_____) _____
(if 18 or over)

Preferred email: _____

FAMILY INFORMATION

Parent's Name: _____ Birth Date: ___/___/___

Home Address: _____

_____

Employer: _____ Work phone: (_____) _____

Parent's Name: _____ Birth Date: ___/___/___

Home Address: _____

_____

Employer: _____ Work phone: (_____) _____

FAMILY MEMBER TO WHOM WE SEND THE BILL

Name: _____ SSN: _____/_____/_____

Address: _____ Phone: (_____) _____

_____ Employer: _____

PLEASE COMPLETE REVERSE SIDE

PRIMARY INSURANCE

Ins. Co. Name: _____ Effective Date: ___/___/___

Policyholder Name: _____ Birth Date: _____

Group No: _____

Policy/ID No: _____

SECONDARY INSURANCE

Ins. Co. Name _____ Effective Date: ___/___/___

Policyholder Name: _____ Birth Date: _____

Group No: _____

Policy/ID No: _____

SIGNATURE REQUIRED:

CANCELLATION NOTICE: If you are unable to keep your appointment, we require 24 hours notification in order to avoid a fee of $30 billed to your account.

PAYMENT AUTHORIZATION NOTICE: In consideration of the services received or to be received, I hereby authorize payment of benefits directly to GREEN ROAD PEDIATRICS, INC. as may be payable to me for such services. I understand that I am financially responsible for charges not covered by this authorization, including deductibles and copayments.

INSURANCE POLICY: We will file your initial claim with your medical insurance company as a COURTESY. We are not responsible for knowing the terms and exclusions in your medical plan. We will, however, do our best to stay within the guidelines of your plan as long as you communicate them to us. In return, prompt payment is expected for services denied, in dispute, or not covered by your insurance plan, as these charges are ultimately your responsibility.

HIPAA PRIVACY NOTICE: I acknowledge that I have reviewed a copy of the Notice of Privacy Practices.

_____ _____

Parent/ Patient Signature (if over 18) Date