FAMILY REGISTRATION

Account#__________________

Date: ______/______/_______

Parent ____ DOB _______/_______/_________ SS # _____________________________

Address ____ Home Phone ____

City/State/ Zip ___________________________________ Occupation ___________________ Cell Phone __________________________

Employer ____ Work Phone __________________ Email ______________________________

Employer Address ____

Parent ____ DOB _______/_______/_________ SS # _____________________________

Address ____ Home Phone ____

City/State/ Zip ___________________________________ Occupation ___________________ Cell Phone __________________________

Employer ____ Work Phone __________________ Email ______________________________

Employer Address ____

Parents are: ☐ Living Together ☐ Separated ☐ Divorced If Divorced, who is the Custodial Parent ______________________________________

Child __________________ Sex ☐ Male ☐ Female DOB __________ Child __________________ Sex ☐ Male ☐ Female DOB __________

Child __________________ Sex ☐ Male ☐ Female DOB __________ Child __________________ Sex ☐ Male ☐ Female DOB __________

Emergency Contact Person: ____

Relationship _____________________________ Home Phone ______________________________ Cell Phone _________________________

Names of individuals, and relationship (other than parents) whom I give permission to bring in my child and be responsible for carrying out the directions given to them by Pediatric Endocrine and Diabetes Associates. Please note that the person bringing in the child is responsible for payment.

_________________________________ ____________________ _________________________________ ____________________

Name Cell phone Name Cell phone

Who may we thank for referring you to us? ____

Insurance Information (you must provide us with a copy of your insurance card)

Insurance Company ________________________________ I.D. ______________________________ Effective Date ____________________

Insurance provided through ☐ Employer ☐ Private ☐ Other ☐ Self Pay Name of Insured ____

Name and full address of Employer ____

Co-Pay $ _____________ Please indicate your primary care physician shown on your card: ____

Authorization of Treatment and Assignment of Benefits:

I authorize Pediatric Endocrine and Diabetes Associates (PEDS) to treat my child/children. I further authorize the release of medical information necessary for the completion of insurance forms and school & camp forms. I authorize payment directly to PEDS for any and all medical or surgical benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse PEDS for any payments my insurance company may have sent me in error. <u>I understand that I am financially responsible for all co-payments and any charges not covered under my insurance benefits.</u> I also understand that I am responsible for advising PEDS of any and all changes to my insurance. <u>Payment of co-pays are due on date of service. Failure to pay co-pay at that time will result in an additional billing charge of $25.00. Our office requires 24 hours notice of appointment cancellation. Failure to provide this notice will incur a cancellation fee.</u>

Signature ____ Relationship ___________________ Date ______________________

A photocopy of this authorization shall be considered as effective and valid as the original.