PATIENT REGISTRATION INFORMATION

Patient Name | **Date of Birth** | **Sex** | **Social Security Number**

Street Address | **City** | **State** | **Zip**

Home Phone | **Mobile** | **Email**

Race ☐ White ☐ Asian ☐ Other (Multi-Racial) ☐ Unknown
☐ Black ☐ American Indian ☐ Hawaiian/Pacific Islander ☐ Decline To Answer

Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Other_____

Primary Language ☐ English ☐ Spanish ☐ Other _____

Primary Contact Name | **Date of Birth** | **Sex** | **Social Security Number**

Street Address (if different from patient) | **City** | **State** | **Zip**

Home Phone | **Mobile** | **Email**

Relationship ☐ Biological Mother/Father ☐ Step Mother/Father ☐ Adopted Mother/Father
☐ Foster Mother/Father ☐ Legal Guardian ☐ Other:_____

Live With Patient ☐ Yes ☐ No

Employer | **Employer Phone #**

Secondary Contact Name | **Date of Birth** | **Sex** | **Social Security Number**

Street Address (if different from patient) | **City** | **State** | **Zip**

Home Phone | **Mobile** | **Email**

Relationship ☐ Biological Mother/Father ☐ Step Mother/Father ☐ Adopted Mother/Father
☐ Foster Mother/Father ☐ Legal Guardian ☐ Other:_____

Live With Patient ☐ Yes ☐ No

Employer | **Employer Phone #**

Emergency Contact Information – Please list someone that <u>does not live with you.</u>

Emergency Contact Name | **Best Phone #** | **Alternate Phone #**

Relationship: _____

Please list the names of any siblings – List only children for which the above family dynamics apply. Continue on back.

Child's Name | **Date of Birth** | **Sex** | **Social Security Number**

Child's Name | **Date of Birth** | **Sex** | **Social Security Number**

Child's Name | **Date of Birth** | **Sex** | **Social Security Number**

_____
Print Name Parent/Guardian

_____ **Date** _____
Signature of Parent/Guardian

PATIENT FINANCIAL INFORMATION

Patient Name	*Date of Birth*	*Sex*	*Social Security Number*

Primary Insurance Information

Primary Insurance Name	**ID #**	**Group #**

Subscriber's Name	**Date of Birth**	**Sex**	**Social Security Number**

Relationship ☐ Biological Mother/Father ☐ Step Mother/Father ☐ Adopted Mother/Father
☐ Foster Mother/Father ☐ Legal Guardian ☐ Other:_____

Secondary Insurance Information

Secondary Primary Insurance Name	**ID #**	**Group #**

Subscriber's Name	**Date of Birth**	**Sex**	**Social Security Number**

Relationship ☐ Biological Mother/Father ☐ Step Mother/Father ☐ Adopted Mother/Father
☐ Foster Mother/Father ☐ Legal Guardian ☐ Other:_____

Financial Guarantor – This is the person that will receive Billing Statements, typically by mail. If listed as contact on the Registration page, then just complete the name.

Parents/Guardians – DV Pediatrics, LLC will not get involved in domestic situations regarding medical payment issues, including who receives the Billing Statement. You must agree on this and work out arrangements amongst yourselves regarding payment issues.

Financial Guarantor Name	**Date of Birth**	**Sex**	**Social Security Number**

Street Address (if different from patient)	**City**	**State**	**Zip**

Home Phone	**Mobile**	**Email**

Relationship ☐ Biological Mother/Father ☐ Step Mother/Father ☐ Adopted Mother/Father
☐ Foster Mother/Father ☐ Legal Guardian ☐ Other:_____

Live With Patient ☐ Yes ☐ No

For all insurance policies, including Medicaid, you are responsible to complete any and all requests for information from them. If not completed your insurance may become invalid, claims denied, and you will be held responsible for your charges.

We must have a copy of your current insurance card on file. You may be held financially responsible for all charges if you fail to provide a current insurance card at time of service.

_____ (Initial) I understand the above statements regarding my responsibilities.

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFITS

I irrevocably assign and transfer to DV Pediatrics, LLC all insurance benefits for payment of all covered medical/surgical services rendered. I authorize payment directly to the Providers of DV Pediatrics, LLC under the terms of my insurance. I understand that I am financially responsible for all insurance covered (allowed) charges whether or not paid by my insurance. This includes co-pays, deductibles, and co-insurance amounts. I authorize the use of this signature on all my insurance submissions. I permit a copy of this authorization to be used in place of the original.

_____
Print Name

_____ **Date** _____
Signature of Parent/Guardian