JONESBORO PEDIATRICS

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Patient Registration Form

Welcome to our office. In order to serve you properly, we will need the following information. **(Please Print)**
All information will be strictly confidential. Also, please provide the receptionist a picture id and your insurance card

Patient's Name): Email Address:	Sex: M F	Birth Date: Age: Primary Language:	Patients Social Security # Ethnicity: Hispanic Non-Hispanic
Residence address: Apt # City State Zip		Primary Phone: Secondary Phone:	Race: Black/African American White Asian Hispanic Native Hawaiian Other No Response
Person financially responsible for this account:	Parent [ ] Other [ ]	Responsible Party's Birthdate: ___/___/____	Responsible Party's Social Security #
Responsible Party Driver's License #: Driver's License State:		Occupation:	How Long at Current Employer:
Name and Address of Employer			Business Phone:
Reason for Visit:	Referred by: (include address and phone)		
Person to contact in case of emergency (Encaso de Emergencia):		Relationship to patient	Phone

Medicaid Yes [ ] No **[ ]**	Medicaid #	Effective Date	How did you hear about us:
Primary insurance company Address			Is insurance through your employer?
Subscriber Name	Subscriber birth date	Policy #	Group #
Secondary insurance name Address		Policy #	Group #

Medicaid Signature on File:

I request that payment of authorized Medicaid benefits be made on my behalf to Jonesboro Pediatrics for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information to determine these benefits payable for related services

_____ _____
Patient, Parent or Guardian Signature (if child is under 18 years old) Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Jonesboro Pediatrics for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims for medical benefits.

_____ _____
Patient, Parent or Guardian Signature (if child is under 18 years old) Date