Neighborhood Pediatrics, LLC
Patient Registration

Chart No.:_____

Patient Information

Patient Name:_____ Patient Date of Birth: _____
Last First Middle Month - Day - Year

Patient Address: _____
Number & Street Apt. # City State Zip

Patient Telephone: (_____)_____Patient Gender: Male ____ Female ___

Patient Allergies: _____S.S. # _____

Family Information

Names of Brothers and Sisters	Date of Birth	Gender	Lives at Same Address as Patient
Name: _____	_____	M F	Yes No
Please Print	Month-Day-Year	Circle One	Circle One
Name: _____	_____	M F	Yes No
Please Print	Month-Day-Year	Circle One	Circle One
Name: _____	_____	M F	Yes No
Please Print	Month-Day-Year	Circle One	Circle One
Name: _____	_____	M F	Yes No
Please Print	Month-Day-Year	Circle One	Circle One

Parents & Legal Guardians

Parent-Legal Guardian 1:

Name:_____Date of Birth: _____
Last First Middle Month - Day - Year

Address: _____
Number & Street Apt. # City State Zip

Home Telephone: (_____)_____ Gender: Male ____ Female ___

Social Security Number: _____ E-mail address: _____

Employer: _____ Position: _____

Employer Address:_____
Number & Street Apt. # City State Zip

Employer Telephone: (_____)_____Cell/Mobile Phone: (_____)_____

Relationship to Patient: ___Biological Parent ____Adoptive Parent ____Foster Parent ____ Step-Parent

Marital Status: ___ Married ____ Widowed ____ Divorced ____ Single

Name of Spouse: _____
Last First Middle

Parent-Legal Guardian 2:

Name:_____Date of Birth: _____
Last First Middle Month - Day - Year

Address: _____
Number & Street Apt. # City State Zip

Home Telephone: (_____)_____ Gender: Male ____ Female ___

Social Security Number: _____ E-mail address: _____

Employer: _____ Position: _____

Employer Address:_____
Number & Street Apt. # City State Zip

Employer Telephone: (_____)_____Cell/Mobile Phone: (_____)_____

Relationship to Patient: ___Biological Parent ____Adoptive Parent ____Foster Parent ____ Step-Parent

Marital Status: ___ Married ____ Widowed ____ Divorced ____ Single

Name of Spouse: _____
Last First Middle

Insurance Information - Please Present Your Insurance Card at Front Desk

Primary Insurance:

Name of Insurance Carrier (Company):_____

Policy Number: _____Group number: _____

Co-Pay Amount: $_____ Effective Date: _____

Subscriber Name: _____Subscriber Date of Birth: _____
Last First Middle Month - Day – Year

Subscriber Social Security Number:_____

Patient's Relationship to Subscriber: _____
(Son - Daughter - Stepchild - Foster Child - Legal Ward - etc.)

Subscriber's Employer: _____

Employer's Address:_____
Number & Street Apt. # City State Zip

Employer's Telephone: (_____)_____

Secondary Insurance: (if applicable)

Name of Insurance Carrier (Company):_____

Policy Number: _____Group number: _____

Co-Pay Amount: $_____ Effective Date: _____

Subscriber Name: _____Subscriber Date of Birth: _____
Last First Middle Month - Day – Year

Subscriber Social Security Number:_____

Patient's Relationship to Subscriber: _____
(Son - Daughter - Stepchild - Foster Child - Legal Ward - etc.)

Subscriber's Employer: _____

Employer's Address:_____
Number & Street Apt. # City State Zip

Employer's Telephone: (_____)_____

Referral

Where did you hear about Neighborhood Pediatrics, LLC? _____

Signature & Consent

I understand that as the individual who brought the patient for medical care at Neighborhood Pediatrics, LLC (NPLLC) that I am responsible for paying for all medical services rendered. I affirm that all of the above information is correct and complete and that the parents or legal guardians are jointly and severally liable for all medical services rendered.

I consent to the release of any information, including medical information, as needed for the billing and reimbursement of my medical claims, including but not limited to, my employer, insurance companies, health maintenance organizations, worker's compensation carriers, and/or third party payors or any authorized agents. I also consent to the release of information to other health care facilities or providers from which I may receive services. This authorization includes the release of information regarding mental health and drug abuse or drug-related conditions. I understand that NPLLC's submission of medical claims to my insurance is performed as a courtesy and that I am ultimately responsible for payment for medical services for the patient.

In consideration of medical services to be rendered, I guarantee payment to NPLLC for all charges incurred, including any portion not pain by any third party payor, or Medicaid. Many third party payors require patients to receive prior authorization/notification for an admission or a procedure to be covered. My failure to comply with such prior authorization may result in me being responsible for payment.

I assign to NPLLC my right to my medical insurance benefits, payable for services rendered. I authorize NPLLC to submit a claim to Medicaid or such third party payor indicated for payment. This assignment is irrevocable. I understand that I am responsible for any unpaid balance due to NPLLC and I guarantee this payment.

By signing below I verify that all of the above information is complete and correct, that I have legal authority to authorize medical treatment for the patient, and that I authorize payment to be made to NPLLC by my insurance carrier.

Print Name: _____ Today's Date: _____

Signature: _____