Pediatric Patient Registration Information

ARCH HEALTH Medical Group

HOW DID YOU HEAR ABOUT US? ☐ NEWSPAPER ☐ SOCIAL MEDIA/WEB SEARCH ☐ INSURANCE REFERRAL ☐ FAMILY/FRIEND

PATIENT INFORMATION

NAME (Last, First, M.I.)	SSN	BIRTH DATE	LANGUAGE	PRIMARY DOCTOR	SEX: ☐M ☐F

PHYSICAL ADDRESS	CITY	STATE	ZIP

MOTHER'S MAIDEN NAME	RACE	ETHNICITY

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME	RELATIONSHIP TO PATIENT	EMERGENCY PHONE

PATIENT'S INSURANCE

NAME OF INSURANCE COMPANY	POLICY #

NAME OF POLICY HOLDER	GROUP #

RELATIONSHIP TO PATIENT	PRIMARY COPAY $	COPAY AMT. SPECIALIST $

ADDRESS OF INSURANCE COMPANY	DEDUCTIBLE AMT. SELF	DEDUCTIBLE AMT. FAMILY

EFFECTIVE DATE	EXPIRATION DATE

PARENTS' INFORMATION

MOTHER'S NAME (Last, First, M.I.)	SSN	BIRTH DATE	LANGUAGE	PRIMARY CARE PROVIDER	SEX: ☐M ☐F

BILLING ADDRESS	CITY	STATE	ZIP

STREET ADDRESS (If different than billing)	CITY	STATE	ZIP

HOME PHONE XXX-XXX-XXXX	WORK PHONE XXX-XXX-XXXX	CELL PHONE XXX-XXX-XXXX	EMAIL

PREFERRED CONTACT METHOD (Required) ☐Home ☐Work ☐Cell ☐Email	MARITAL STATUS	MAIDEN NAME	RACE	ETHNICITY

RELATIONSHIP TO PATIENT

FATHER'S NAME (Last, First, M.I.)	SSN	BIRTH DATE	LANGUAGE	PRIMARY CARE PROVIDER	SEX: ☐M ☐F

BILLING ADDRESS	CITY	STATE	ZIP

STREET ADDRESS (If different than billing)	CITY	STATE	ZIP

HOME PHONE XXX-XXX-XXXX	WORK PHONE XXX-XXX-XXXX	CELL PHONE XXX-XXX-XXXX	EMAIL

PREFERRED CONTACT METHOD (Required) ☐Home ☐Work ☐Cell ☐Email	MARITAL STATUS	RACE	ETHNICITY

RELATIONSHIP TO PATIENT

CUSTODIAL INFORMATION

CUSTODIAL PARENT IS
☐ Mother ☐ Father ☐ Other_____

FINANCIAL POLICY: Payment in full or co-payment is expected at the time of service. Services provided that are not a covered benefit of your health plan will be your responsibility.

CONSENT TO TREATMENT/RELEASE OF INFORMATION: I grant Arch Health Medical Group, to administer medical treatment and perform medical procedures as deemed necessary. I authorize the release of medical information to my insurer, or the insurer's agents to process my payments for service. To the best of my knowledge, all of the information above is true and correct.

ASSIGNMENT OF BENEFITS: I thereby assign all benefits payable by my insurance company to Arch Health Medical Group.

TREATMENT IF PARENT OR GUARDIAN IS NOT PRESENT: CHILD MUST must have a note from a parent or guardian giving permission for Arch Health Medical Group to examine child. Please Include in this note the date of visit, any known allergies, the name of the person bringing in the child and his or her relationship to the child, and reason for visit. Forms are available if you'd like to have one for reference. Please ask the Receptionist for details.

Patient / Guardian Signature _____ Date _____ Relationship to Patient _____