



***PATIENT REGISTRATION FORM***

Date: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ Your Name/Relation to Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Race \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_ Cell Phone: (    ) \_\_\_\_\_

Email: \_\_\_\_\_ Caringbridge Web Address (if applicable): \_\_\_\_\_

School/Daycare: \_\_\_\_\_

Referred By: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Pediatrician (PCP): \_\_\_\_\_ Phone Number: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Child's Other Physician(s) (besides Pediatrician): \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address (if different from patient): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_ Cell Phone: (    ) \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Marital Status: \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address (if different from patient): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_ Cell Phone: (    ) \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Marital Status: \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insured**

Guarantor's Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_

Social Security #: \_\_\_\_\_ Employer: \_\_\_\_\_

Primary Insurance Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Type: \_\_\_ HMO \_\_\_ PPO \_\_\_ PPC other: \_\_\_\_\_ Co-Pay Amount: \_\_\_\_\_

If you belong to an HMO, do you also have other Group Insurance Coverage? \_\_\_ Yes \_\_\_ No

**Secondary Insured**

Guarantor's Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_

Social Security #: \_\_\_\_\_ Employer: \_\_\_\_\_

Primary Insurance Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Type: \_\_\_ HMO \_\_\_ PPO \_\_\_ PPC other: \_\_\_\_\_ Co-Pay Amount: \_\_\_\_\_

**NOTIFY IN CASE OF EMERGENCY**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

I understand that payment of all medical care is due at the time of service. In case of divorced parents, responsibility and payment shall be that of the guardian bringing the child in for treatment. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. I understand that I am responsible for any costs incurred in the collection of patients account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Palm Beach Pediatric Hematology Oncology to release any pertinent information to my insurance company upon request, and I authorize payment directly to Palm Beach Pediatric Hematology Oncology. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_