

Pediatric Associates of Mt. Carmel, Inc.

Patient Registration

Patient Name _____

Medical Record # _____

Patient's Address _____ County _____

Sex M F SS# _____

DOB _____

Siblings/Ages _____

Who does patient live with?

Father Mother Both Parents Shared Parenting grandparents Legal Guardian

Father's Information / Responsible Party

Name _____

Relationship to Patient _____

Address _____
Same As Patient - Circle Here

City State Zip

DOB _____ SS# _____

Home Phone _____

Work Phone _____

Cell Phone _____

Mother's Information / Responsible Party

Name _____

Relationship to Patient _____

Address _____
Same As Patient - Circle Here

City State Zip

DOB _____ SS# _____

Home Phone _____

Work Phone _____

Cell Phone _____

Primary Insurance

Company _____

Policy # _____

Group # _____

Employer _____

Subscriber Name _____

Relationship to patient _____

Secondary Insurance

Company _____

Policy # _____

Group # _____

Employer _____

Subscriber Name _____

Relationship to patient _____

Emergency Contact (Not living in home)

Relationship to Patient :

Name

Phone Number :

If you are new to the practice, how did you hear about our us?

- Family Friend Newspaper Radio Phone Book Website
- Signage Insurance Company Directory Other Physicians Hospital _____

I hereby assign all medical benefits to which the patient is entitles to Pediatric Associates of Mt. Carmel, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, paid or not paid, by said insurance. I also authorize Pediatric Associates to evaluate and treat any and all medical conditions during this and subsequent visits. Updated 5/2008

Signed _____ Date _____