KIDS CLINIC
Patient Registration Form

Patient Information

Today's Date: ___________________ Name of Patient: ____
Last First Middle

DOB: __________________________ Sex: M ☐ F ☐ Patient's Social Security # (optional): ________-______-________

Physical Address: ____ City:_________________________ State: _______ Zip: ___________
Mailing Address: ____ City: _________________________State: _______ Zip: ___________

Mom's Cell: (______)________-__________ Dad's Cell: (______)________-__________ Home Phone: (______)________-_________

Race:__________________Ethnicity:__________________________Language Preference:_____________________________________

Name of Birth Mother:______________________________________Name of Birth Father:____________________________________
Name of Step Mother:______________________________________ Name of Step Father:____________________________________
Name of Siblings____

Parent /Legal Guardian / Responsible Party Information

Relationship to patient: Self ☐ Mother ☐ Father ☐ Step-Parent ☐ Guardian ☐ Foster Parent ☐

Name:____ DOB: ___________________

Physical Address: ____City:_______________________ State:_____ Zip:_______________
(if different than above)

Mother's Employer: _________________________________ City: ______________________ Phone: (______)_______-_____________

Father's Employer: __________________________________ City: ______________________ Phone: (______)_______-_____________

Email Address for patient portal: ____

Person to be notified in case of an emergency (other than at your address)

Name: ____Cell Phone #: (_____)_____-_______Home Phone #: (_____)_____-_________

Relationship to Patient: ____ Consent to treat & disclose? *Yes* ☐ ***OR*** *No*
**If yes, signed consent must be on file*

Primary Insurance

Name of Insurance____ Subscriber's Social Security Number_______-______-_______

Policy #:____ Group #:___________________________Co-Pay: ___________

Name of Subscriber: ____Employer:____

Subscriber's DOB: ____Subscriber's Relationship to Patient: ______________________

Secondary Insurance

Name of Insurance____ Subscriber's Social Security Number_______-______-_______

Policy #:____ Group #:___________________________Co-Pay: ___________

Name of Subscriber: ____Employer:____

Subscriber's DOB: ____Subscriber's Relationship to Patient: _____________________
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AUTHORIZATION TO PAY PHYSICIAN AND RELEASE INFORMATION

I hereby assign to R.D. Jones all payments to which I am entitled for medical and surgical expenses related to the services performed by them and directs that checks be made to them. I also authorize the above physician to release such information (including a copy of this form) as may be required by my ATTORNEY and/or INSURANCE COMPANY and/or REFERRING DOCTOR and/or PRACTITIONER Dr. R.D. Jones may refer me to. In addition, I accept all financial responsibility. I understand that if the information I have provided Dr. Jones is not sufficient to bill my insurance or if services are not paid in full by my insurance within the contracted limits, I will be responsible for the outstanding balance to be paid in full within 90 days. I also give authorization to send me a reminder via text or email.

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Patient/Parent/Legal Guardian/Responsible Party **Date** **Relationship**