PATIENT REGISTRATION

PATIENT REFERRED BY_____TODAY'S DATE_____
PATIENT NAME_____SOC. SEC. #. _____
STREET ADDRESS_____DATE OF BIRTH_____ AGE_____
CITY/STATE_____ ZIP _____TEL #._____
CELL #._____E-MAIL ADDRESS_____

FATHER / GUARDIAN INFORMATION

NAME_____ MARITAL STATUS S M W SEP D
STREET ADDRESS_____CITY/STATE_____ZIP_____
DOB_____SOC.SEC #._____E-MAIL ADDRESS_____
EMPLOYER NAME_____
EMPLOYER ADDRESS_____CITY/STATE_____ZIP_____
OCCUPATION_____
TEL. #._____CELL #._____WORK #._____

MOTHER / GUARDIAN INFORMATION

NAME_____ MARITAL STATUS S M W SEP D
STREET ADDRESS_____CITY/STATE_____ZIP_____
DOB_____SOC.SEC #._____E-MAIL ADDRESS_____
EMPLOYER NAME_____
EMPLOYER ADDRESS_____CITY/STATE_____ZIP_____
OCCUPATION_____
TEL. #._____CELL #._____WORK #._____

EMERGENCY INFORMATION

NAME_____CELL #_____HOME #_____
RELATIONSHIP_____

NAME_____CELL #_____HOME #_____
RELATIONSHIP_____

INSURANCE INFORMATION

PRIMARY INSURANCE CO. NAME ID# PLAN GROUP

SUBSCRIBER'S NAME DOB RELATIONSHIP SUBSCRIBER'S EMPLOYER

SECONDARY INSURANCE CO. NAME ID# PLAN GROUP

SUBSCRIBER'S NAME DOB RELATIONSHIP SUBSCRIBER'S EMPLOYER

CONSENT TO TREAT AND FINANCIAL AGREEMENT

I/ We do hereby consent to and authorize the performance of all treatments, minor surgery and medical services by Pediatric Endocrinology Associates which they deem advisable.

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits, to include major benefits to which I am entitled, including medical, private insurance or any other health plan to Pediatric Endocrinology Associates. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment. I hereby certify that, to the best of my knowledge all statements contained hereon are true. I understand that I am directly responsible for all charges incurred by medical services for myself and my dependents regardless of insurance coverage. I furthermore agree to pay legal interest, collection expense, and attorney's fees, should it become necessary to assign any amount I may owe for collection. I fully understand that this agreement, consent and assignment of benefits will continue until cancelled by me in writing.

REMARKS _____
Signed_____ Date_____ Witness_____ Date_____