Minor Patient Registration Form

Child's Name: _____ Date of Birth: _____/_____/_____
First Middle Last Month Day Year

Prefer to be called: _____ Who Referred You? _____

If Student: ❑ Full Time ❑ Part Time Name of School: _____

Home Address: _____
Street# Street Name Apt#

_____
City State Zip

Legal Guardian or
Parent Name: _____ Date of Birth: _____/_____/_____
First Middle Last Month Day Year

Employer: _____
Name Address Phone

Home Phone: _____ Work Phone: _____

Social Security Number: _____ Sex: ❑ M ❑ F

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial polices of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA AND MASTERCARD FOR YOUR CONVENIENCE. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the Doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the Doctor when an assigned claim is filed.

It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service.

_____ _____
Signature of parent or legal guardian Date

Name of policy owner if other than patient:_____

Patient relationship to policy owner: ❑ Self ❑ Child ❑ Other: _____

Should the account fall into the arrears greater than 60 days, I authorize that unpaid balance to be charged to my major credit card, as listed below.

Please present insurance cards and photo ID to the receptionist so copies may be made.

Do we have your permission to:

Leave a message on your answering machine at home? ❑ YES ❑ NO
Leave a message at your place of employment? ❑ YES ❑ NO
Discuss your medical condition with any member of your household? ❑ YES ❑ NO

If yes, whom: _____ Relationship _____

_____ _____
Parent / Legal Guardian Signature Date