PATIENT REGISTRATION FORM **ROYALE PEDIATRIC HEALTHCARE, PC**

NAME

GENDER ☐ M ☐ F

DATE OF BIRTH

PREFERRED PHONE #: ( )

STREET ADDRESS

CITY, STATE

ZIP CODE

SCHOOL NAME & ADDRESS

☐ N/A (PLEASE EXPLAIN):

REFERRED BY

☐ DOCTOR:_____

☐ HOSPITAL: _____

☐ FRIEND/FAMILY MEMBER ☐ OTHER ☐ N/A

PARENT 1 INFORMATION

☐ MOTHER ☐ FATHER ☐ LEGAL GUARDIAN

☐ SELF (For patients 18+/Emancipated Minors: I am the primary & only insurance holder)

☐ OTHER (DESCRIBE RELATIONSHIP TO PATIENT): _____

NAME: _____

OCCUPATION/EMPLOYER: _____

DATE OF BIRTH: _____ HOME PHONE #: (_____)_____

MOBILE PHONE #: (_____)_____ WORK PHONE #: (_____)_____

PREFERRED METHOD OF CONTACT: ☐ HOME ☐ MOBILE ☐ WORK

PARENT 2 INFORMATION

☐ N/A: (PARENT 1 HAS PRIMARY & SOLE FINANCIAL RESPONSIBILITY FOR PATIENT)

☐ MOTHER ☐ FATHER ☐ LEGAL GUARDIAN

☐ OTHER (DESCRIBE RELATIONSHIP TO PATIENT): _____

NAME: _____

OCCUPATION/EMPLOYER: _____

DATE OF BIRTH: _____ HOME PHONE #: (_____)_____

MOBILE PHONE #: _____ WORK PHONE #: (_____)_____

PREFERRED METHOD OF CONTACT: ☐ HOME ☐ MOBILE ☐ WORK

EMERGENCY CONTACT

A person **other** than patient's parents/legal guardian, to be contacted in case of emergency a medical emergency, if patient's parents/legal guardian cannot be reached.

NAME:_____

RELATIONSHIP TO PATIENT: _____

MOBILE PHONE #: (_____)_____ HOME PHONE #: (_____)_____

WORK PHONE #:(_____)_____

PREFERRED METHOD OF CONTACT: ☐ HOME ☐ MOBILE ☐ WORK

PRIMARY INSURANCE

INSURANCE COMPANY: _____

ADDRESS (See back of insurance card): _____

ID #: _____ GROUP #: _____

EFFECTIVE DATE: _____ BENEFIT CODE: _____

SUBSCRIBER'S NAME: ☐ PARENT 1 (see above) ☐ PARENT 2 (See above)

☐ SELF (For patients 18+/Emancipated Minors)

RESPONSIBLE PARTY

☐ PARENT 1 (As Listed above) ☐ PARENT 2 (As listed above)

☐ SELF (For patients 18+/Emancipated Minors)

BILLING ADDRESS:

_____

_____

SECONDARY INSURANCE

INSURANCE COMPANY: _____

ADDRESS (See back of insurance card): _____

ID #: _____ GROUP #: _____

EFFECTIVE DATE: _____ BENEFIT CODE: _____

SUBSCRIBER'S NAME: ☐ PARENT 1 (see above) ☐ PARENT 2 (See above)

☐ SELF (For patients 18+/Emancipated Minors)

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to **Dr. Rosemarie Francisque-St. Victor** for services rendered by her in person/under her supervision. **I understand I am financially responsible for any balance not covered by my insurance.**

MEDICAID - MEDICARE

I certify that the information given by me in applying payment is correct. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be as valid as the original.

PATIENT NAME (PLEASE PRINT): _____ DATE: _____

PARENT/GUARDIAN NAME (PLEASE PRINT): _____ SIGNATURE: _____