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:** _____