FAMILY REGISTRATION

Doctors' Pediatric, P.C.

Account #__________

Date____________

PARENT (Mother)__________________ DOB__________ SS #__________

Address__________________ Home Phone__________

City/State/Zip__________________ Occupation__________ Cell #__________

Employer__________________ Work #__________ Email__________

PARENT (Father)__________________ DOB__________ SS #__________

Address__________________ Home Phone__________

City/State/Zip__________________ Occupation__________ Cell #__________

Employer__________________ Work #__________ Email__________

Parents are ☐ Living Together ☐ Separated ☐ Divorced. If Divorced, who is the custodial parent__________

Child__________ Sex_____ DOB_______ Child__________ Sex_____ DOB_______

Child__________ Sex_____ DOB_______ Child__________ Sex_____ DOB_______

Child__________ Sex_____ DOB_______ Child__________ Sex_____ DOB_______

Who may we thank for referring you to us?__________________

Emergency Contact Person: __________________

Relationship__________ Home Phone__________ Cell Phone__________

Consent to Treat: Names of individuals, and relationship (other than parents), of persons whom I give permission to bring in my child/children and be responsible for carrying out the directives given to them by Doctors' Pediatric, P.C. Please note that the person bringing in the child is responsible for payment.

Name:__________________ Cell Phone__________

Name:__________________ Cell Phone__________

Insurance Information (you must provide us with a copy of your current insurance card)

Insurance Company __________________ I.D. __________

Effective Date__________ Co-pay__________

Insurance provided through: ☐ Employer ☐ Private ☐ Other ☐ Self Pay **Name of Insured**__________

NOTE: You need to select one of our physicians as your primary care physician and notify your insurance of selection.
Please indicate name of physician shown on your card: __________________

Your preferred **Pharmacy:** __________ Location: __________

Authorization of Treatment and Assignment of Benefits: I authorize Doctors' Pediatric, P.C., to treat my child/children. I further authorize the release of medical information necessary for the completion of insurance forms, school and camp forms. I authorize payment directly to Doctors' Pediatric, P.C., for any and all medical or surgical benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse Doctors' Pediatric, P.C. for any payments my insurance company may have sent to me in error. I understand that I am financially responsible for all co-payments and any charges not covered under my insurance benefits. I also understand that I am responsible for notifying Doctors' Pediatric, P.C. of any and all changes to my insurance. Payment of co-pays are due on date of service. Failure to pay co-pay at that time will result in an additional billing charge of $10. Our office requires 24 hours notice of appointment cancellation. Failure to provide this notice will incur a cancellation fee.

Signature__________________ Relationship__________ Date__________

A photocopy of this authorization shall be considered as effective and valid as the original.

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10 South Street, Suite 206, Ridgefield, CT 06877 (203) 431-3363