Patient Registration Information

Please PRINT and complete ALL sections below!

PATIENT'S PERSONAL INFORMATION

Name: ______________________________ ______________________________ __________
Last Name First Name Initial

Date of Birth: _____ / _______ / ________ Social Security #: ______ / ______ / _______

Home Phone: ______________________ Work Phone: ________________ Cell Phone: _________________

Who has legal guardianship of child: ____
Name/Relationship

Child currently lives with: ____
Name/Relationship

PATIENT'S INSURANCE INFORMATION

Please present insurance card(s) and drivers license to receptionist.

PRIMARY Insurance Name: ____

Address: ______________________________ City: ____________ State: ___ Zip: ______

Name of insured: ________________________ Date of birth: ____________________

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: ________________________ Group #: ____________________________

SECONDARY Insurance Name: ____

Address: ______________________________ City: ____________ State: ___ Zip: ______

Name of insured: ________________________ Date of birth: ____________________

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other ___________________

Policy #: ________________________ Group #: ____________________________

PHARMACY INFORMATION

Name: ____

Address: ______________________________ City: ______________ State: ___ Zip: ______

Phone: ________________________ Fax: ______________________________

RESPONSIBLE PARTY /GUARANTOR/ INFORMATION

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other ______

**** The parent and/or legal guardian who brings the patient for their visit is responsible for payment independent of what a divorce decree may state. Reimbursement must be made between the divorced parents. We will not intervene.**

Name: ______________________________ ______________________________ __________
Last Name First Name Initial

Date of Birth: _____ / _______ / ________ Social Security #: ______ / ______ / _______

Home Phone: ______________________ Work Phone: ________________ Cell Phone: _________________

Address: ____ City: ________________ State: ___ Zip: ______

Employer Name: ____

Employer Address: ____

Employer Phone #: ____

Would you like to communicate with us via e-mail? Yes ______ No _______
Your e-mail address: ____

Would you like to have an access to our Patient Portal? Yes _______ No ________________

EMERGENCY CONTACT INFORMATION

Name: _________________________________ _____________________________________ ________
Last Name First Name Initial

Date of Birth: _____ / _______ / ________ Social Security #: ______ / ______ / _______

Home Phone: _____________________ Work Phone: _______________ Cell Phone: ________________

Address: ____ City: ________________ State: ___ Zip: ______

Assignment of Benefits • Financial Agreement

I herby give lifetime authorization for payment of insurance benefits to be made directly to Hilltop Pediatrics, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: ________________ Your Signature: ____