OWENSBORO PEDIATRICS
PATIENT REGISTRATION

① Patient Information

Name (First, Middle, Last):_____ Male☐ Female☐
Social Security #:_____ Date of Birth:_____
Home Address:_____
City:_____ State:_____ Zip:_____
Home Phone:_____ Email Address:_____

Signature:_____Date:_____
**Signature here allows us to leave a messages at the numbers listed via voicemail, person, etc*

② List of Siblings

Name_____ Male☐ Female☐ Date of Birth_____
Name_____ Male☐ Female☐ Date of Birth_____
Name_____ Male☐ Female☐ Date of Birth_____
Name_____ Male☐ Female☐ Date of Birth_____

③ Parent/Guardian Information-1

Name:_____
Date of Birth:_____
SS#:_____
Address:_____
City, State, Zip:_____
Employer:_____
Home Phone:_____
Cell Phone:_____
Work Phone:_____
Email:_____
Relationship to Patient:_____
Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced

Parent/Guardian Information-2

Name:_____
Date of Birth:_____
SS#:_____
Address:_____
City, State, Zip:_____
Employer:_____
Home Phone:_____
Cell Phone:_____
Work Phone:_____
Email:_____
Relationship to Patient:_____
Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced

Guarantor/responsible Party:_____

In case of separated or divorced parents, who is the custodial parent? _____

PLEASE TURN OVER

④ Primary Insurance Information

Please provide your insurance card to the Receptionist

Insurance Company:_____

Subscriber's Name:_____ Date of Birth:_____ SS#:_____

Policy Number:_____ Group #:_____

⑤ Secondary Insurance Information

Please provide your insurance card to the Receptionist

Insurance Company:_____

Subscriber's Name:_____ Date of Birth:_____ SS#:_____

Policy Number:_____ Group #:_____

⑥ Emergency Contact Other Than Parent

Name of Contact:_____

Phone #:_____

Relationship to Patient: ☐ Step Parent ☐ Grandparent ☐ Aunt/Uncle ☐ Other_____

⑦ Other Person(s) Allowed to Bring Patient to the Office

Name of Contact:_____

Phone #:_____ Relationship to Patient: ☐ Step Parent ☐ Grandparent ☐ Aunt/Uncle ☐ Other

Name of Contact:_____

Phone #:_____ Relationship to Patient: ☐ Step Parent ☐ Grandparent ☐ Aunt/Uncle ☐ Other

Name of Contact:_____

Phone #:_____ Relationship to Patient: ☐ Step Parent ☐ Grandparent ☐ Aunt/Uncle ☐ Other

⑧ Private Insurance Authorization for Assignment of Benefits/Information Release

I, the undersigned, authorize payment of medical benefits to Owensboro Pediatrics for any services furnished to me by the physicians. I understand that I am financially responsible for any copays, coinsurance, deductibles, non-covered services, and percentages that are not covered by my contract at the time of service. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating claims of benefit.

_____ _____

Signature (Parent/Guardian) Date