

Designated Choice for
PCP _____

SANFORD PEDIATRICS REGISTRATION FORM

1801 Doctors Drive, Sanford, NC 27330

Date _____

PATIENT NAME _____ SS# _____
(last) (first) (middle)

DATE OF BIRTH _____ Sex _____ Email address _____

PHONE NUMBERS: Home _____ Cell _____ Preferred contact method: home cell email

RESPONSIBLE PARTY _____ Address _____

City _____ State _____ Zip _____

MOTHER'S NAME _____ SS# _____

Date of Birth _____ Employer _____ Work # _____

FATHER'S NAME _____ SS# _____

Date of Birth _____ Employer _____ Work # _____

BROTHERS AND SISTERS

NAME _____ DATE OF BIRTH _____

NAME _____ DATE OF BIRTH _____

NAME _____ DATE OF BIRTH _____

EMERGENCY CONTACT (Other than parents) _____ Relationship _____

Address _____ Phone # _____

(Optional information-please check here if you do not wish to list

PREFERRED LANGUAGE _____ RACE _____ ETHNICITY Hispanic/Latino (or) non-Hispanic/Latino

#1 Policy Holder _____ Employer _____

Insurance Co. _____ Claims Address _____

Policy # _____ Group # _____

#2 Policy Holder _____ Employer _____

Insurance Co. _____ Claims Address _____

Policy # _____ Group # _____

MEDICINE ALLERGIES: _____

METHOD OF PAYMENT: _____ Cash _____ Check _____ Bankcard _____ Medicaid

PREFERRED PHARMACY: _____

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO SANFORD PEDIATRICS. " I hereby authorize Sanford Pediatrics, P.A. to release information acquired in the course of my examination and treatment. I hereby assign payment directed to the designated physician for any medical procedures performed. I understand I am responsible and will pay for any services not covered by my insurance company."

SIGNATURE _____

(parent or guardian, if patient is a minor)

PARENTAL/GUARANTOR PERMISSION TO TREAT "I give permission for physicians of Sanford Pediatrics, P.A., or persons designated by them, to interview, examine and perform necessary laboratory/radiological procedures and to provide appropriate treatment to the above named minor. Permission for evaluation and treatment is granted whether child is presented by parent, other family member, unrelated third party, or unaccompanied."

SIGNATURE _____

(parent or guardian, if patient is a minor)