

<u>Pediatric Patient Registration</u>		Date
<i>Confidential Patient Information</i>		- -
Child's Legal Name		Child's Birthdate
Father's Name		- -
Father's Address		Father's Birthdate
		- -
City/State/Zip		Home #
		- -
Father's Occupation	Father's Employer/Employer's Address	Work/Cell #
		- -
Father's SSN	Father's Driver's License #/State	
- -		
Mother's Name		Mother's Birthdate
		- -
Mother's Address		Home #
		- -
City/State/Zip		Work/Cell #
		- -
Mom's Occupation	Mother's Employer/Employer's Address	Employer's #
		- -
Mother's SSN	Mother's Driver's License #/State	Name Of Parent
- -		<u>Financially Responsible</u>
	Person To Notify In Case Of Emergency (<u>not living w/child</u>)	For Medical Bills:
Name		Contact #
Home Address		- -
City/State/Zip		
How Did You Hear About This Office?		Pharmacy Name
Family/Primary Physician		Pharmacy Location
Known Allergies		Pharmacy #
Insurance Holder		- -

I authorize all physicians employed by Asthma Allergy Centre to furnish my insurance company with all information requested concerning my claim. I assign to Asthma Allergy Centre all benefits from my insurance policy or any other policies covering my condition. I am financially responsible to Asthma Allergy Centre for all charges not paid by my insurers. I agree to pay all reasonable court costs and attorney fees incurred by Asthma Allergy Centre in collecting unpaid balances owing to them. I am aware that unpaid balances 90 days after billing will result in a service charge of \$5.00 per month until all portions of the balance 90 days and older have been paid. **RESPONSIBLE PARTY SIGNATURE:** **Date:**