Children's Medical Group, P.C.

Patient Registration

Today's Date: ____________ Who is your regular doctor? Rosdeutscher ____ Fairbank ____ Randolph ____ Toole-Rollins ____

Patient's Name: Last ____________________ First ____________________ Middle ____________________

Date of Birth: __________ Patient's Age ______ ☐ Male ☐ Female Patient's Social Security Number ________________

Primary Language: English ____ Spanish ____ Other ____ Ethnic Group: ________________________________

Race: Asian ____ Alaska Native____ Black/African American____ Caucasian/White____ Hispanic or Latino____ Other____ Decline____

Do you have any other children who see our doctors? Yes ______ No ______

If yes, what are their names? ____

Patient's Address: ________________________________ City ________________ State ____ Zip ________

Patient's Phone: ____________________________ Is Parent's Address different from child? Yes____ No____

Mother's Phone:______________Address: ______________________ City __________ State ____ Zip ________

Father's Phone: ______________Address: ______________________ City __________ State ____ Zip ________

Primary Email Address For Patient Portal: ________________________________

Employment / Insurance Information

Mother's Name: ______________________________

Mother's Date of Birth: ______________________________

Social Security # ______________________________

Mother's Employer ______________________________

Employer's Phone ______________________________

Mother's Insurance ______________________________

ID # ________________ Group # ______________

Claims Address ______________________________

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Father's Name: ______________________________

Father's Date of Birth: ______________________________

Social Security # ______________________________

Father's Employer ______________________________

Employer's Phone ______________________________

Father's Insurance ______________________________

ID # ________________ Group # ______________

Claims Address ______________________________

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In the event of an emergency, whom may we contact? (outside home)

Name ________________________ Address ____

Relationship to Child ____________________ Phone ____________________

Other than parents, who else has permission to bring your child in for treatment?

Name ______________ Relationship to Child ________ Name ______________ Relationship to Child ________

Responsible Party:

The policy in our office is: ***The parent who requests treatment for the child is responsible for all the fees for services rendered.***

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Responsible Party Signature

Assignment:

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for charges whether or not they are paid by insurance. I hereby authorize said assignee to release all information to secure payment.

____________________________ ________________
Signature Date