

Pediatric Sports and Spine Associates

REGISTRATION FORM

(Please Print)

Today's Date:						
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	Birth Date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Patient's Social Security no.:		Home phone no.: ()	
P.O. box:		City:		State:	ZIP Code:	
Work:		Primary Care Physician:		Phone no.:		Address:
Cell:						
Chose clinic because/referred to clinic by (Please check one box):						
<input type="checkbox"/> Family		<input type="checkbox"/> Friend		<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Dr.
				<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Seen in ER:
				<input type="checkbox"/> Other:		<input type="checkbox"/> Hospital:
Other family members seen here:						

INSURANCE INFORMATION						
(Please give your insurance card & driver's license to the receptionist.)						
Person responsible for bill:		Birth date:	Address (if different):		Home phone no.(if different): ()	
Occupation:	Employer:		Employer address:		Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Name of primary insurance:				Insurance Co. Phone no.:		
Subscriber's name:		Subscriber's SS no.:	Birth date:	Group no.:	ID no.:	Co-payment: \$
ID no. (Amerigroup) (Medicaid) (Texas Star)				Effective through:		
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	ID no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.:	Work phone no.:
			()	()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Pediatric Sports and Spine Associates or the insurance company to release any information required to process my claims.				
_____ <i>Patient/Guardian signature</i>			_____ <i>Date</i>	