Please use: BLACK INK

Northwest Pediatric Center

Please include all children who are under 18 years old and who have the same biological parents and live in the same household on one Registration Form

Patient #				
First Name				
Middle Name				
Last Name				
Birthdate	_____/_____/_____	_____/_____/_____	_____/_____/_____	_____/_____/_____
School				

Contact 1: Parent/Guardian (This contact will be the ONLY person receiving appointment reminders)

Check one: ___ Mother ___ Step-Mother ___ Foster Mother ___ Legal Guardian
___ Father ___ Step-Father ___ Foster Father ___ Other:_____

Is this the patient(s) Primary Residence? Yes _____ No _____

Name:_____
First M.I. Last Social Security Number DOB

Mailing Address: _____
Street City State Zip Code

Employer: _____ Occupation: _____

Email Address: _____

Cell Phone Number: _____

Contact 2: Parent/Guardian (This contact will NOT receive appointment reminders)

Check one: ___ Mother ___ Step-Mother ___ Foster Mother ___ Legal Guardian
___ Father ___ Step-Father ___ Foster Father ___ Other:_____

Is this the patient(s) Primary Residence? Yes _____ No _____

Name:_____
First M.I. Last Social Security Number DOB

If address is the same as Contact 1 - Check here _____ (skip to "Employer" - no need to write address below)

Mailing Address: _____
Street City State Zip Code

Employer: _____ Occupation: _____

Email Address: _____

Cell Phone Number: _____

WHO IS CUSTODIAL PARENT? (If applicable) _____

Emergency Contact: _____ Relationship to Patient _____ Phone: _____
(other than contacts listed above – enter friend or relative not living with you)

IF INSURANCE CARDS ARE NOT PRESENTED AT EACH VISIT YOU WILL BE CONSIDERED SELF PAY

Financial Responsibility

I understand that I am financially responsible for all charges, regardless of my insurance coverage. It is my responsibility to notify NWPC of my insurance at each visit and to update NWPC when I have a change. If my insurance requires a copay, that copay must be paid at the time of service. I understand that I am responsible for any amount not covered by my insurance plan. If I do not have insurance, payment is required at the time of service unless other arrangements have been made in advance with the billing department. If it becomes necessary for NWPC to turn my account over to a collection agency on of any amount owed on this or subsequent visits, I agree to pay for all costs and expenses, including reasonable attorney fees. I hereby assign to the physician/provider all payments for medical services rendered. I hereby authorize Northwest Pediatric Center to release information necessary to secure payment of benefits. I have read the above policy.

Signature of Parent/legal guardian: _____ Date: _____

Print Name: _____ updated _____