St. Petersburg Pediatrics

PATIENT REGISTRATION (Please print clearly) **REGISTRATION FORM**

Patient Name _____ Date of Birth _____

Siblings _____ Child lives with: Mom ☐ Dad ☐ Both ☐ Other ☐

Mothers Full Name _____

Address _____City_____ Zip _____

Cell Phone _____ ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Email Address _____

Fathers Full Name _____

Address _____City _____ Zip _____

Cell Phone _____

Referred by: _____

In case of emergency, contact (other than parent) _____

Address _____ City _____ Zip _____

Relationship _____ Phone# _____

INSURANCE INFORMATION _____

Primary Coverage, Name of Carrier:

_____

Group # _____

Identification # _____

Subscriber name: _____

Subscriber D.O.B _____

Effective Date _____

Secondary Coverage, Name of Carrier:

_____

Group # _____

Identification # _____

Subscriber name: _____

Subscriber D.O.B _____

Effective Date _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS; I authorize St. Petersburg Pediatrics to release any medical information in connection with these services for health insurance purposes or to any physician involved in the ongoing treatment of this patient.

I further agree to pay all collection costs and attorney fees should the account become delinquent and be referred to a collection agency.

Parent/Guardian Signature _____
Date _____

OUT OF NETWORK INSURANCE PLANS ONLY; I understand that St. Petersburg Pediatrics will file my insurance claims for services rendered to the patient as an out-of- network or non-contracted provider. I understand that I will be financially responsible for all applicable non-paid charges.
PLEASE INITIAL_____

We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for payment. As a courtesy, however, we will prepare any necessary reports and itemizations to assist in making collections from insurance and will credit any such collections to the patient account.

PAYMENT AUTHORIZATION

_____

I, _____ hereby authorize SI. Petersburg Pediatrics to furnish information concerning my present illness. I direct the insurer to pay, without equivocation directly to St. Petersburg Pediatrics, all benefits due as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all charges. A photostatic copy of this authorization will be as valid as the original.

Signature of Patient: _____ Date: _____

A PHOTOCOPY OF ALL INSURANCE CARDS AND DRIVER'S LICENSE IS REQUIRED