

Brighton Pediatric Center

Registration Form

PATIENTS INFORMATION						
(Please list all children we will be caring for)						
Last Name	First Name	MI	M/ F	DOB	Chart #	
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PARENTS INFORMATION						
Home Street Address			City	State	Zip	Phone () -
Father's Name	Occupation/ Employer		DOB / /	CELL PHONE () -	SSN - -	
Mother's Name	Occupation/ Employer		DOB / /	CELL PHONE () -	SSN - -	
Guardian's Name	Occupation/ Employer		DOB / /	CELL PHONE () -	SSN - -	
Emergency Contact (Other than Parents)			Relationship		Phone () -	
INSURANCE & BILLING INFORMATION						
Person Financially Responsible: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other			Relationship:			
PRIMARY INSURANCE:			SECONDARY INSURANCE:			
Subscriber's Name			Subscriber's Name			
Insurance ID			Insurance ID			
Group # /or Name of Employer			Group # /or Name of Employer			
Effective Date			Effective Date			
Address			Address			
PAYMENT REQUIRED AT TIME OF SERVICE- UNLESS PRIOR ARRANGEMENT HAS BEEN MADE						
ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY						
<p>The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform Brighton Pediatric Center of any changes in my minor's/ child's medical status. Insurance status, and / or financial status. Additionally, I will inform Brighton Pediatric Center of any address changes that may affect billing.</p> <p>I certified that my minor/ child is covered by the above insurance company/ companies, and I assign directly to Brighton Pediatric Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Brighton Pediatric Center, and doctors associated with Brighton Pediatric Center to release all information necessary to process a claim. I authorize the use of this signature on all my submissions, whether manual or electronic. <i>A photocopy of these assignments shall be as valid as the original</i></p> <p>Signature _____ Date _____/_____/_____</p>						
HOW DID YOU HEAR ABOUT US						
<input type="checkbox"/> Friend/ Relative _____		<input type="checkbox"/> Hospital _____		<input type="checkbox"/> Yellow Pages _____		
<input type="checkbox"/> Another Physician _____		<input type="checkbox"/> Insurance Co _____		<input type="checkbox"/> Internet _____		
<input type="checkbox"/> Other _____						