PATIENT REGISTRATION INFORMATION

PATIENT INFORMATION- Please **enter for all children to be seen at the practice**				
CHILD'S NAME (LAST, FIRST,MIDDLE)	Name	DOB	SEX	RACE
CHILD'S NAME (LAST, FIRST,MIDDLE)				
CHILD'S NAME (LAST, FIRST,MIDDLE)				
CHILD'S NAME (LAST, FIRST,MIDDLE)				

PATIENT ADDRESS- Patient(s) reside(s) with ☐ both parents ☐ mother ☐ father ☐ other			
ADDRESS (STREET AND APT OR BOX)	CITY	STATE	ZIP

PHARMACY INOFRMATION- Where you want your prescription sent		
PHARMACY NAME	ADDRESS OR MAJOR CROSS STREETS	PHONE

GUARANTOR INFORMATION- The person financially responsible for the patient, usually the one holding the insurance				
NAME (LAST, FIRST, MIDDLE)		RELATIONSHIP TO PATIENT	DOB	SOCIAL SECURITY #
ADDRESS, IF DIFFERENT FROM THE PATIENT		CITY	STATE	ZIP
HOME PHONE	CELL PHONE	EMAIL ADDRESS	EMPLOYER	WORK PHONE

OTHER PARENT INFORMATION				
NAME (LAST, FIRST, MIDDLE)		RELATIONSHIP TO PATIENT	DOB	SOCIAL SECURITY #
ADDRESS, IF DIFFERENT FROM THE PATIENT		CITY	STATE	ZIP
HOME PHONE	CELL PHONE	EMAIL ADDRESS	EMPLOYER	WORK PHONE

INSURANCE INFORMATION- Please present insurance card(s) to the receptionist					
PRIMARY INSURANCE (Company that will be billed first)			SECONDARY INSURANCE		
GROUP NUMBER	POLICY NUMBER	CO-PAYMENT	GROUP NUMBER	POLICY #	CO-PAYMENT

HOW DID YOU HEAR ABOUT US?

ARE THERE ANY RELIGIOUS PREFERENCES OR ACCOMOODATIONS?

EMERGENCY CONTACT-When parents are not available			
NAME(LAST,FIRST)	RELATIONSHIP	HOME PHONE	CELL PHONE

Assignment of Benefits: In the event the patient, his/her authorized representative or the guarantor signing below, is entitled to benefits of any type arising out of any policy of insurance insuring the patient or any other party liable for the patient, those benefits are hereby assigned to Healthy Horizons Pediatrics to the patient's bill. Such payment shall discharge the insurance company of any obligation under the policy to the extent that the payment has been made accordingly to the terms of the policy. The undersigned shall remain responsible for any and all charges not paid by the insurance company and/or covered by the assignment. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable for this patient, is hereby assigned to Healthy Horizons Pediatrics.

Parent/Guardian Signature: _____ Date: _____

Financial Responsibility: I agree that in return for the services provided to the patient of Healthy Horizons Pediatrics and /or any assisting physicians or providers, I will pay the account of the patient prior to discharge or make financial arrangements satisfactory to Healthy Horizons Pediatrics. In the event of default, I agree to pay all costs of collections, and reasonable attorney's fees. A delinquent account (60 days from date of service) will be charged a $10.00 billing fee and may be charged interest at the legal rate. In addition, I have read and understand Healthy Horizons Pediatrics' Financial Policy.

Parent/Guardian Signature: _____ Date: _____