Patient Registration Form

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Patient Identification - Please Print

Patient's Last Name	First	Middle	Office Use Only Chart No.:

Age	Date of Birth / /	Sex O M O F	Social Security Number	Email Address:

Street Address	City	State	Zip Code

Mailing Address - if different than above	Home Phone ( ) -	Cell Phone ( ) -
Name of Custodial Parent(s)	Home Phone ( ) -	Work Phone ( ) -
Address - if different than above		
Name of Non-Custodial Parent(s)	Home Phone ( ) -	Work Phone ( ) -
Address - if different than above		

Responsible Party

Name of person(s) responsible for this account Last Name First Name Middle	Home Phone ( ) -	Work Phone ( ) -

Social Security Number	Date of Birth / /	Relationship to Patient: O Mother O Father O Legal Guardian O Other - Explain
Address - if different than above		
Employer Name / Address		

Insurance Information (please give your insurance card to the receptionist)

Primary Coverage- Name of Insurance Company	Address		
Policy or Certificate Number	Insured's ID Number	Group Number	Effective Date
Name of insured/policyholder/subscriber Last Name Fir: First Name	Social Security Number	Date of Birth / /	Occupation
Home Phone ( ) -	Work Phone ( ) -	Address - if different than above Employer / Address	

Secondary Coverage-Name of Insurance Company	Address		
Policy or Certificate Number	Insured's ID Number	Group Number	Effective Date
Name of insured/policyholder/subscriber Last Name Fir: First Name	Social Security Number	Date of Birth / /	Occupation
Home Phone ( ) -	Work Phone ( ) -	Address - if different than above Employer / Address	

Emergency Contact Information

Name of local relative or friend (not living at same address)	Home Phone ( ) -	Work Phone ( ) -
Relationship to patient:		

The above information is true to the best of my knowledge. I authorize insurance benefits to be paid directly to Aasha Pediatrics, Inc. and I understand that I am financially responsible for any self-pay/co-pay/co-insurance/deductible amounts. I also authorize Aasha Pediatrics, Inc. or the insurance company to release any information required to process my claim(s). I authorize a copy of this authorization to be used in place of the original. I authorize Aasha Pediatrics, Inc. to apply for benefits on my behalf for covered services rendered by any provider within the clinic or by their order. As a parent or legal guardian, I give permission for the Physicians at Aasha Pediatrics, Inc. to treat the patient listed above. I have also received the HIPPA Notice of Privacy Rights and Practices.

Signature:_____ Date:_____

Patient / Parent / Guardian

How did you hear about us? _____