RUTHERFORD PEDIATRICS - PATIENT REGISTRATION FORM

Date: _____

Name of Child:

_____

First Name Middle Name Last Name Date of birth

Home Address: _____

City: _____ State: _____ Zip Code: _____

Preferred contact phone number:

Home: _____ Mom Cell _____ Father Cell _____

Work Numbers: Mother _____ Father _____

Parents: Married ☐ Single ☐ Divorced ☐ Partners ☐
Custody: Mother ☐ Father ☐ Joint ☐

Mother's Name: _____ Date of Birth _____

Father's Name: _____ Date of Birth _____

Who is responsible for the insurance: Mother ☐ Father ☐

Employed by: _____

Primary Insurance Company Name: _____ Policy Eff. _____
Date

Policy # _____ Group # _____

Insurance Address: _____
(located on back of insurance card)

Assignment & Release: I hereby authorize payment directly to Rutherford Pediatrics for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for my dependents.

I authorize Rutherford Pediatrics and/or any provider or supplier of services in this office to release the information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date: _____