



PATIENT REGISTRATION

Patient	Sex M/F	Date of Birth	
Patient	Sex M/F	Date of Birth	
Patient	Sex M/F	Date of Birth	
Patient	Sex M/F	Date of Birth	
Address	City	State	Zip
Home Phone #	E-mail		
Billing Address (if different from patient's address)	City	State	Zip
Father's Full Name	SSN	Date of Birth	
Father's Employer	Cell Phone		
Father's Business Phone	E-mail		
Mother's Full Name	SSN	Date of Birth	
Mother's Employer	Cell Phone		
Mother's Business Phone	E-mail		
In case of emergency, who should we contact? (Please provide a name other than parent)			
Name	Relation	Home Phone	Cell Phone

INSURANCE INFORMATION

Insurance Company	ID#	Group #	
Subscriber	Effective Date		
Secondary Insurance	ID#	Group #	
Subscriber	Effective Date		

PHARMACY PREFERENCES

Day Pharmacy	Phone	Fax	E-mail
24 Hr Pharmacy	Phone	Fax	E-mail

AUTHORIZATION FOR TREATMENT AND PAYMENT POLICY INCLUDING ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the Doctors and staff of Boulevard Pediatrics to treat the medical condition(s) of my child(ren), and further authorize my signature below for use on any and all insurance claims submitted on our behalf for such services. I hereby irrevocably accept financial responsibility for all medical and related services received while under medical care, and assign any and all insurance benefits otherwise payable by the insurance company for said services. I, the undersigned, understand that I am financially responsible for any and all charges not covered by insurance, and further understand that payment of co-payments and/or deductibles for services received are due at the time that services are rendered.

Updated: _____ Date: _____
 Updated: _____ Date: _____
 Updated: _____ Date: _____
 Updated: _____ Date: _____

 Signature of Parent or Guardian

 Date