Pediatric Associates
Young Adult Patient Information Registration Form
Please fill out form completely & legibly

Patient Name_____ **Responsible Party: SELF**

Last First Middle

SS#:_____ Telephone#(___)_____DOB: _____

Patient Email:_____

Mailing Address_____

City State ZIP

Physical Address_____

(if different than mailing address) City State Zip

Insurance Information

Insurance Company Name_____

Subscriber Name_____ Subscriber DOB:_____

Relationship to patient:_____ Subscriber Employer_____

Subscriber/ID#_____ Group #_____ SS#_____

Insurance Company Name_____

Subscriber Name_____ Subscriber DOB:_____

Relationship to patient:_____ Subscriber Employer_____

Subscriber/ID#_____ Group #_____ SS#_____

I, _____, hereby authorize the following individuals may have access to my medial and billing information. I understand that this is part of HIPAA compliance and that I may revoke these privileges by notifying Pediatric Associates at anytime.

1._____ relationship_____ DOB____

2._____ relationship_____ DOB____

3._____ relationship_____ DOB____

I understand that by signing below that the information I have provided is true and complete to my knowledge. I also understand that I am required by Pediatric Associates to provide a copy of my current insurance card(s) at each visit. **I recognize and accept responsibility for any balances and acknowledge outstanding balances are due immediately upon receipt of a statement.**

Patient Signature_____ Date:_____