

PATIENT REGISTRATION

DATE

Name:	M F	Date of Birth:	Age:
Street Address:		City, State, Zip:	Phone: ()
School/Day Care:		Referred By:	Childs' SS#:
Father's Name:		Date of Birth:	SS#:
Occupation/ Employer:		Contact/Work phone: ()	
Mother's Name:		Date of Birth:	SS#:
Occupation/ Employer:		Contact/Work phone: ()	
Guardian (Other, Self):		Date of Birth:	SS#:
Emergency Contact (Other than Parents):		Address:	Phone: ()
Closest Relative(s) (Not at your address):		Address:	Phone: ()

Insurance & Billing Information

Person(s) Responsible:	Father	Mother	Other	Relationship:
Billing Address:				

Assignment of Insurance Benefits

I hereby authorize direct payment of medical/surgical benefits to **Addie J. Briggs, MD** for services rendered by her or under her supervision. I understand that I am financial responsible for any balance not covered by my insurance.

Authorization to Release Information

I hereby authorize Dr. Addie Briggs, to release any medical o incidental information that may be necessary for either medical care of in processing applications for financial benefit.

Medicaid

I certify that the information given by me in applying for payment is **correct**. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

(A photocopy of the assignments shall be as valid as the original)

Patient's Name (Print) _____ **Date** _____

Parent/Guardian (Print) _____ **Signature** _____

INSURANCE INFORMATION

The rules and restrictions of managed care are complex. Please be familiar with your benefit manual so as to fully understand your coverage responsibilities and rights.

Copy of card:

I hereby authorize East End Pediatrics, P.C. to release to my insurance company any information they should request contained in the medical records to assist their efforts to assure quality delivery of care.

I accept responsibility for payment of my bill including co-pays, deductibles or non covered services requested by me. In the event my account is not paid when billed and placed in the hands of an attorney for collections, I agree to be responsible for the cost, including 33 1/3% attorney fees, court cost and interest on the principal balance of 18% per annum from the date of service.

Signature of Parent or Guardian _____ Date _____

MR#: _____

Name: _____

Date of Birth: _____

SOCIAL HISTORY

PLEASE LIST **ALL** PEOPLE(S) IN THE HOUSEHOLD:

<u>NAME</u>	<u>RELATIONSHIP TO CHILD</u> (EX. MOTHER, BROTHER, COUSIN)	<u>DOB</u>

Does **ANYONE** in the home **SMOKE**? YES NO

FAMILY HISTORY

Have any of the **CHILD'S** brother(s) or sister(s) died? YES NO
(IF YES, PLEASE LIST THE AGE AT DEATH & CAUSE) _____

Have any of the **CHILD'S BLOOD RELATIVES** HAD ANY OF THE FOLLOWING DISEASES? If YES, LIST THE FAMILY MEMBER

	<u>FAMILY MEMBER</u> (Ex.: Father, Sister, Grandmother)
Allergies	<input type="checkbox"/> YES <input type="checkbox"/> NO _____
Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO _____
Mental /Emotional problem	<input type="checkbox"/> YES <input type="checkbox"/> NO _____
Stroke	<input type="checkbox"/> YES <input type="checkbox"/> NO _____
High Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO _____
Kidney Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO _____
Heart Disease <u>or</u> Heart Attack	<input type="checkbox"/> YES <input type="checkbox"/> NO _____
Cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO _____
Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO _____
High Cholesterol	<input type="checkbox"/> YES <input type="checkbox"/> NO _____
Seizures	<input type="checkbox"/> YES <input type="checkbox"/> NO _____
Other	<input type="checkbox"/> YES <input type="checkbox"/> NO _____

Please list any other HEALTH ISSUES: _____

