

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** _____