Amarillo Pediatric Clinic PLLC

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Patient Registration Form

Patient Information

	Sex: -----Male -----Female	DOB:
Last Name, First Name MI	Email:	SSN:

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ Preferred: ___Home/___Cell

Parent Information

MOTHER	FATHER
Last Name First Name MI DOB: SS#:	Last Name First Name MI DOB: SS#:
Mailing Address:_____ _____ City: State: Zip Code:	Mailing Address:_____ _____ City: State: Zip Code:
Home Phone:	Home Phone
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:
Email:	Email:
Employer:	Employer:
Occupation:	Occupation:
Marital Status: -----Single -----Married -----Separated -----Divorced	Marital Status: -----Single -----Married -----Separated -----Divorced
Custody: ___Both Parents ___Mother ___Father ___Other:_____	
Party Responsible for Payment: ___Mother ___Father ___Other:_____	

Emergency Contact(s)

Contact Name (not living in the home) / Relationship / Home Phone / Work Phone / Cell Phone

_____/_____/_____/_____/_____

_____/_____/_____/_____/_____

Individuals who MAY give consent for treatment / Relationship / Home Phone / Work Phone / Cell Phone

_____/_____/_____/_____/_____

_____/_____/_____/_____/_____

Authorization

The above information is true to the best of my knowledge. I authorize that my insurance benefits be paid directly to Amarillo Pediatric Clinic. I understand my insurance carrier may pay less than the actual bill of service and I agree to be financially responsible for any balance and for all services rendered. I authorize Amarillo Pediatric Clinic to release information including diagnosis and records of treatment or examinations during the period of such care to third party payers and/or other health practitioners.

_____ _____

Patient/Other Legally Authorized Person **Date**

_____ _____

Print Name and Relationship to Patient **Witness**