Patient Registration

Child's Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Date of Birth _____ Age _____
Sex _____ SS# _____

Preferred Pharmacy _____
Drug Allergies _____

Names of Brother(s) and/or Sister(s)
_____Age _____
_____Age _____
_____Age _____
_____Age _____

Mother _____
Date of birth _____ SS# _____
Employed by _____
Work # _____ Cell # _____
Email Address _____

Father _____
Date of birth _____ SS# _____
Employed by _____
Work # _____ Cell # _____
Email Address _____

Primary Insurance _____
Insured's Name _____
Insured's Date of Birth _____SS#_____
Policy # _____ Group # _____

Secondary Insurance _____
Insured's Name _____
Insured's Date of Birth _____SS#_____
Policy # _____ Group # _____

Assignment of Benefits
I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including medicare, private insurance, and any other plan to Aaron C. Polk, Jr., M.D. and/or Carl A. Davis, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment and to request a review of claim.

Signed _____ Date _____