

## Star Family medicine Pediatric registration form

**Patient information:** (children under age 18)

Last name \_\_\_\_\_ First Name \_\_\_\_\_

Street address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M\_\_ F\_\_ Student? Yes\_\_ No\_\_

**Responsible Party Information:** (the person who accompanies the child to the visit)

Last name: \_\_\_\_\_ First name: \_\_\_\_\_

Street address: \_\_\_\_\_ Same as patient \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Last name(other parent): \_\_\_\_\_ First name \_\_\_\_\_

Street address: \_\_\_\_\_ Same as patient \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

**Primary Insurance Information:**

Subscriber's name: \_\_\_\_\_ ID #: \_\_\_\_\_ GR #: \_\_\_\_\_

Subscriber's DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation to patient: \_\_\_\_\_

Insurance carrier name: \_\_\_\_\_ Effective date: \_\_\_\_\_

Subscriber's address: \_\_\_\_\_

**Secondary Insurance Information:**

Subscriber's name: \_\_\_\_\_ ID #: \_\_\_\_\_ GR #: \_\_\_\_\_

Subscriber's DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation to patient: \_\_\_\_\_

Insurance carrier name: \_\_\_\_\_ Effective date: \_\_\_\_\_

Subscriber's address: \_\_\_\_\_

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payer, health maintenance organization, insurer or other health benefit plan. This consent applies to STAR FAMILY MEDICINE, PC, or any of its affiliates or agents, lenders, or any third party services acting for FPPC, PC, or any of its affiliates.

I agree to promptly pay for the services rendered for me or the patient named above. If I fail to meet my financial commitment to STAR FAMILY MEDICINE and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees. I further agree to pay for any missed appointments of which I did not notify the medical office within a reasonable amount of time.

I authorize STAR FAMILY MEDICINE to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician for services.

Signed \_\_\_\_\_ Date: \_\_\_\_\_