Patient Registration Form

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Franklin, TN 37067
615-778-1840
Fax: 615-778-1841
www.southernpeds.com

Patient Name: ______________________________

Gender (circle one) **Male / Female** **Date of Birth** ______________ **SSN#**______________

Address______________________________

City ______________ **State** ______________ **Zip**______________

Primary Phone:______________ ____**Alternate Number:** ______________

Parent/Guardian (PRIMARY):______________________________

Parent/Guardian (PRIMARY) email address:______________________________

Parent SS# :______________ **Date of Birth:**______________

Parent/Guardian (SECONDARY):______________________________

Parent SS# ______________ **Date of Birth** ______________

Insurance Information

Primary Insurance Carrier:______________________________

Policy ID#:______________**Group#:**______________

Claims Address:______________________________

City:______________ **State:**______________ **Zip:** ______________

Place of Employment:______________ **Phone:** ______________

******PLEASE PRESENT COPY OF YOUR CARD AT EACH APPOINTMENT** COPAYS, DEDUCTIBLES AND NON-COVERED SERVICES ARE DUE AT THE TIME OF SERVICE***

Secondary Insurance Carrier:______________________________

Policy ID#:______________**Group#:**______________

Claims Address:______________________________

City:______________ **State:**______________ **Zip:** ______________

Place of Employment:______________ **Phone:** ______________

******PLEASE PRESENT COPY OF YOUR CARD AT EACH APPOINTMENT******

Would you like a copy of the HIPPA Privacy Notice? YES / NO (circle one)

Other Information

Please List any Siblings: ______________________________

Pharmacy Name& Address: ______________ **Phone #:** ______________

Emergency Contact:______________________________

Address______________________________**Phone#**______________

Please list any person (other than parent or emergency contact) **allowed to give /receive information about your child's healthcare(This may include other siblings**

Name : ______________ **Relationship:**______________

Name : ______________ **Relationship:**______________

This signature authorizes Southern Pediatrics, PLLC permission to treat your child, file appropriate insurance claims, and hold you financially responsible for any services preformed for your child's care. **Should your account be referred to an outside collection agency, you will be responsible for any collection fees.**

Signature:______________________________ **Date:** ______________