

PATIENT REGISTRATION

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301 Lennon Lane Ste 203
Walnut Creek, CA 94598

CHILD'S LAST NAME: _____ FIRST NAME: _____ M.I: _____
CHILD'S STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
HOME PHONE:() _____ BIRTHDATE: MONTH _____ DAY _____ YEAR _____
SEX: _____ MALE _____ FEMALE _____ SOC. SEC # _____ - _____ - _____
IN CASE OF EMERGENCY, NOTIFY: _____ PHONE: _____

PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN #1: _____ ADDRESS(IF DIFFERENT): _____
HOME PHONE:() _____ WORK PHONE:() _____
CELL PHONE:() _____ RELATION: _____ SS#: _____

PARENT/GUARDIAN #2: _____ ADDRESS(IF DIFFERENT): _____
HOME PHONE:() _____ WORK PHONE:() _____
CELL PHONE:() _____ RELATION: _____ SS#: _____

INSURANCE INFORMATION

PRIMARY INS: _____ POLICY #: _____
GROUP #: _____ EFFECTIVE DATE: _____
MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED OTHER
STUDENT STATUS: FULL-TIME PART-TIME
POLICY HOLDER NAME, IF DIFFERENT THAN ABOVE: _____
YOUR RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER
REFERRING PROVIDER: _____
SECONDARY INS: _____ POLICY #: _____
GROUP #: _____ EFFECTIVE DATE: _____
POLICY HOLDER NAME, IF DIFFERENT THAN ABOVE: _____
YOUR RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

FINANCIAL AGREEMENT & RELEASE OF INFORMATION

Casa Verde Pediatrics will bill certain insurance plans in which we are a participating provider. Patients are required to pay applicable co-payments at the time of service. When we are notified by your insurance carrier(s) of any non-covered services, deductibles, or additional co-payments, we will send you a bill. You are required to pay this bill upon receipt. Please remember that this is a courtesy to you and that our billing your insurance plan does not release you of the financial responsibility of your medical services. I understand that I am financially responsible to Casa Verde Pediatrics for all charges incurred. I authorize Casa Verde Pediatrics to furnish information from my records to any insurer of mine. Further, I authorize payment to Casa Verde Pediatrics of the health insurance benefits otherwise payable to me, but not to exceed the regular charges for this period of care. I understand that I am financially responsible to Casa Verde Pediatrics for the charges not paid by my insurance plan(s).

Signature: _____ Date: _____