REGISTRATION FORM

PATIENT_____ _____ _____
LAST NAME FIRST NAME MI

SEX M F AGE_____ DATE OF BIRTH ____/____/____ SOCIAL SECURITY#_____

GUARDIAN_____ RELATIONSHIP TO PATIENT_____
LAST NAME FIRST NAME MI

SEX M F AGE_____ DATE OF BIRTH ____/____/____ SOCIAL SECURITY#_____

CELL PHONE (_____)_____ HOME PHONE (_____)_____

ADDRESS_____APT# _____

CITY_____ STATE_____ ZIP_____

PRIMARY
INSURANCE_____

INSURED'SNAME_____RELATION TOPATIENT_____

ID#_____SOCIALSECURITY#_____ GROUP#_____ DATE OF BIRTH____/____/____

SECONDARY
INSURANCE_____

INSURED'S
NAME_____RELATIONSHIPTOPATIENT_____

ID#_____SOCIALSECURITY#_____ GROUP#_____ DATE OF BIRTH____/____/____

INCASEOFEMERGENCYNOTIFY
PHONE(_____)_____ _____

REFERRINGDOCTOR_____PHONE(_____)_____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims or benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I hereby authorize my insurance carrier to pay and hereby assign directly to Hanan Pediatrics PC all benefits, if any, otherwise payable to me for physician services as described on the claim forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by me and paid to Hanan Pediatrics PC, will be credited to my account, in accordance with the above said assignment. I hereby agree and understand that if I receive payment from my insurance company for services rendered by physician(s) at Hanan Pediatrics PC, I am to endorse the check and mail with statement to his office. I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill. I acknowledge and understand the fact that if for some reason I fail to submit payment on my account and my account is being reported to a collection agency, collection fee of 20% of the balance will be added to my account.

PATIENT'S SIGNATURE_____ DATE ___/___/___

GUARDIAN'S SIGNATURE_____ DATE ___/___/___