PATIENT REGISTRATION I *PEDIATRIC SURGICAL ASSOCIATES*

PATIENT Information

Name: _____ Birth Date: ____/____/____
First Middle Last

Address: _____ Age: _____ Male / Female

City: _____ State: _____ Zip: _____

Home Phone: ( ) - Social Security # : - -

Primary Care Doctor: _____ Office Phone: ( ) -
First Last

Referred By Doctor: _____ Office Phone: ( ) -
First Last

PARENT Information - Mother or Legal Guardian

Name: _____ Birthdate: ____/____/____
First Middle Last

Address: _____ Marital Status: M W D S

City: _____ State: _____ Zip: _____

Home Phone: ( ) - Social Security # : - -

Cell Phone: ( ) - Work Phone: ( ) -

Employer: _____ Occupation: _____

PARENT Information - Father or Legal Guardian

Name: _____ Birthdate: ____/____/____
First Middle Last

Address: _____ Marital Status: M W D S

City: _____ State: _____ Zip: _____

Home Phone: ( ) - Social Security # : - -

Cell Phone: ( ) - Work Phone: ( ) -

Employer: _____ Occupation: _____

OTHER CONTACT Information - NOT Parent

Name: _____ Relationship to Patient: _____
First Last

Home Phone: ( ) - Cell Phone: ( ) -

Health Plan / Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

ID # : _____ ID # : _____

Group # : _____ Group # : _____

Subscriber's Name: _____ Subscriber's Name: _____

Subscriber's Relationship to Patient: _____ Subscriber's Relationship to Patient: _____

Name of Person Completing this form : _____

_____ _____ _____
Signature *Relationship to Patient* *Date*

AUTHORIZATION TO TREAT

I and/or the undersigned, on behalf of the patient, voluntarily Consent to allow Pediatric Surgical Associates, Inc. physicians, it's affiliated physicians and staff to provide such evaluation and/or care and treatment as an outpatient on a continuing basis and as an inpatient as necessary, as Pediatric Surgical Associates, Inc. physicians, it's affiliated physicians and staff may decide is advisable and necessary.

I and/or the undersigned, on behalf of the patient, am advised that such treatment may include physical examination, x-ray examination, laboratory procedures, other office procedures as well as inpatient procedures as required.

I and/or the undersigned, on behalf of the patient, understand that I will be informed about the course of my treatment.

I and/or the undersigned, on behalf of the patient, am free to terminate my treatment with my physician at any time.

FINANCIAL RESPONSIBILITY

I and/or the undersigned, on behalf of the patient, understand that I am financially responsible for all charges, whether or not paid by my insurance, unless specifically exempted by my insurance company's contract with Pediatric Surgical Associates, Inc. and it's affiliated physicians.

ASSIGNMENT OF BENEFITS

I and/or the undersigned, on behalf of the patient, hereby assign medical and/or surgical benefits, private insurance and any other health plan benefits to Pediatric Surgical Associates, Inc. and it's affiliated physicians. A copy of this assignment is considered valid as the original.

AUTHORIZATION TO RELEASE INFORMATION

I and/or the undersigned, on behalf of the patient, hereby authorize Pediatric Surgical Associates, Inc. and it's affiliated physicians to release my medical information necessary to my insurance company or it's agents in order to secure payments.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I and/or the undersigned, on behalf of the patient, understand that I am acknowledging that I have been provided a personal paper copy of Pediatric Surgical Associates, Inc.'s Notice of Privacy Practice as required by law. The law requires this medical practice to document the fact that they have distributed the notice by collecting and retaining a signed acknowledgement.

My signature below acknowledges that I received a copy of this practices Notice of Privacy Practice and that a copy of the current notice will be posted in the reception area.

If after reviewing the Notice of Privacy Practice you decide that you do not want to retain your copy, please return it to our receptionist and we will recycle it.

PATIENT & PARENT OR LEGAL GUARDIAN INFORMATION

Patient Name	Patient Date of Birth (/ /)	
Parent or Legal Guardian Name	Signature	Date
Relationship to Patient		