Muddy Creek Pediatrics LLC

PATIENT REGISTRATION FORM ***DATE:____/____/____***

PATIENT INFORMATION ☐ New Patient ☐ Update

Children's Names (under age18)	**Date of Birth**	**Sex**	**Primary Doctor**
______________________	____________	M / F	__________________
______________________	____________	M / F	__________________
______________________	____________	M / F	__________________
______________________	____________	M / F	__________________

Patient's Primary Address: ____
(Street) (City, State, Zip)

Emergency Contact (not living with you):_______________________Phone:____________

Emergency Contact Relationship to Patient:__________________

Preferred Language: English Other (please specify): ______________________
Ethnicity (circle one): Hispanic or Latino Not Hispanic or Latino Decline to specify
Patient Race (circle one):

American Indian/Alaskan native
Asian
Black/African American
White/Caucasian
Pacific Islander/Hawaiian Native
Decline to specify

Father's Information: **Authority (circle one): Joint Exclusive None**

Name: ______________________ DOB: ____________ S.S.#______________
Address: ____
(Street) (City, State, Zip)
Home Phone: ____________________ Home Email____________________
Cell Phone: ____________________ Work Email: ____________________
Work Phone: ____________________ Employer Name: ________________

Mother's Information: **Authority (circle one): Joint Exclusive None**

Name: ______________________ DOB: ____________ S.S.#______________
Address: ____
(Street) (City, State, Zip)
Home Phone: ____________________ Home Email____________________
Cell Phone: ____________________ Work Email: ____________________
Work Phone: ____________________ Employer Name: ________________

Please also complete back of this form

Step-Parent (if applicable): ____

Authority (circle one): Joint / Exclusive / None

Legal Guardian (if applicable)____

Authority (circle one): Joint / Exclusive / None

***Please note, if someone other than parents have legal guardianship of the patient, appropriate paperwork will need to be provided to Muddy Creek.**

Insurance and Billing Information:

Primary Insurance Coverage: __________________ Member ID#____________________
Subscriber Name: _____________________ DOB: ____________ SS#: _______________
Employer: ____
Effective Date of Coverage: _____________ Relationship to Patient:___________________

Secondary Insurance Coverage: ________________ Member ID#____________________
Subscriber Name: ________________ DOB: ____________ SS#: _____________________
Employer: ____
Effective Date of Coverage: _____________ Relationship to Patient:___________________

Preferred Pharmacy:_____________________ Location: ________________________

SIGNATURE REQUIRED

PATIENTS OVER THE AGE OF 18 MUST PROVIDE A SIGNATURE UNLESS A LEGAL GUARDIAN HAS BEEN ASSIGNED BY THE COURT.

I hereby authorize Muddy Creek Pediatrics LLC (MCP) to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by MCP health care providers and hereby direct my insurance carrier or its intermediaries to issue payment directly to Muddy Creek Pediatrics LLC on behalf of such rendered services.
I understand that I am financially responsible to the office for any balance not covered by my insurance carrier.
I further certify that I have received, read, and agree with the MCP Privacy Policy document.

____
Signature Date

Who may we thank for the referral? ____