Muddy Creek Pediatrics

OVER 18 PATIENT REGISTRATION FORM **Date: / /**

Patient Information

Patient Name*:* _____ **D.O.B*:*** _____ ***Sex: M / F***

Address:_____**S.S.#**_____
(Street) (City, St., Zip)

Home Phone: _____ **Cell:** _____**Primary Email:**_____

Preferred Pharmacy:_____**Location**:_____

Father's Name: _____ **Primary Phone**:_____

Mother's Name: _____ **Primary Phone**: _____

Emergency Contact: _____ **Relation to you:** _____ **Phone**: _____

Insurance and Billing Information

Primary Insurance Coverage*:* _____ ***Member I.D. #*** _____

Subscriber Name: _____ D.O.B. _____ SS # _____

Subscriber relationship to patient: _____ Employer: _____

Secondary Insurance Coverage*:* _____ ***Member I.D. #*** _____

Subscriber Name: _____ D.O.B. _____ SS # _____

Subscriber relationship to patient: _____ Employer: _____

SIGNATURE REQUIRED

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.

Patient Signature: _____ **Date:**_____