

Muddy Creek Pediatrics LLC

PATIENT REGISTRATION FORM

DATE: ___/___/___

PATIENT INFORMATION

New Patient Update

<u>Children's Names</u> (under age18)	<u>Date of Birth</u>	<u>Sex</u>	<u>Primary Doctor</u>
_____	_____	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	White/Caucasian
Asian	Pacific Islander/Hawaiian Native
Black/African American	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? _____