Premiere Childrens Physicians, P.A.
701 N. Bridge Street
Suite 104, Northside Plaza
Elkton, MD 21921
(410) 398-5930

PATIENT REGISTRATION

Name: ______________________ DOB: ____________ Gender: ( ) Male ( ) Female

SS#: _____ - _____ - ______ Street Address: ______________________

City, State ZIP: ______________________ Phone Number: ______________________

Father's Name: ______________________ SS#: _____ - _____ - ______ DOB: ____________

Mother's Name: ______________________ SS#: _____ - _____ - ______ DOB: ____________

Guardian Name: ______________________ SS#: _____ - _____ - ______ DOB: ____________

Emergency Contact: ______________________ Phone Number: ______________________
(Other than Parents)

INSURANCE & BILLING INFORMATION

Person Responsible: ☐ Father ☐ Mother ☐ Other (Please list name & relationship) ______________________

Billing Address: ______________________ Phone #: ______________________

PAYMENT REQUIRED AT TIME OF SERVICE – UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE

1) Insurance Company: ______________________ Address: ______________________

Subscriber's Name: ______________________ ID #: ______________________

Group #: ______________________ Effective Date: ____________ Co-pay Amount: ____________

2) Insurance Company: ______________________ Address: ______________________

Subscriber's Name: ______________________ ID #: ______________________

Group #: ______________________ Effective Date: ____________ Co-pay Amount: ____________

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to Premiere Childrens Physicians, P.A. for services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Premiere Childrens Physicians, P.A. release any medical or incidental information that may be necessary to either medical care or in processing applications for financial benefit.

MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

Patient (Please Print): ______________________ Date: ______________________

Parent / Guardian (Please Print): ______________________ Signature: ______________________