Lakeview Pediatrics, LLC

Patient Registration

Patient and Family Information

Child's Name______________________________ Birthdate_____________ ☐Male ☐Female
Social Security#__________________________Phone__________________________________
Home Address____
City____ State_________ Zip_________________
School____ Grade___________________
Responsible Party____
Relationship To Child____

Name of Mother/Guardian__________________________________Birthdate_______________
Social Security#__________________________Phone__________________________________
Home Address____
City____ State_________ Zip_________________
Employer______________________________ Business Phone__________________________
Cell Phone_____________________________Email____________________________________

Name of Father/Guardian__________________________________Birthdate_______________
Social Security#__________________________Phone__________________________________
Home Address____
City____ State_________ Zip_________________
Employer______________________________ Business Phone__________________________
Cell Phone_____________________________Email____________________________________

Assignment and Release

I hereby authorize payment directly to Lakeview Pediatrics for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or *any* provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party ______________________________Date______________