KID-DOC
PEDIATRICS
Patient Registration

PATIENT(S) DEMOGRAPHIC(S)

Patient Name: _____ SSN _____ DOB _____ Sex: M☐ F ☐

Patient Name: _____ SSN _____ DOB _____ Sex: M☐ F ☐

Patient Name: _____ SSN _____ DOB _____ Sex: M☐ F ☐

Street Address: _____ Apt #: _____

City/State/Zip: _____ Email: _____

Race (please circle): Am Indian/AK Native Asian Black/African American Native HI/Pacific IS White Prefer not to answer
Ethnicity (please circle): Hispanic/Latino Non-Hispanic/Latino Prefer not to answer

PARENT'S INFORMATION Relationship to Child (please circle): Mother Father Grandparent Legal Guardian

Name _____ DOB _____ SSN _____ Driver's Lic _____

Employer Name _____ Occupation _____ Cell _____ Work _____

Employer Address _____ City/State/Zip _____

PARENT'S INFORMATION Relationship to Child (please circle): Mother Father Grandparent Legal Guardian

Name _____ DOB _____ SSN _____ Driver's Lic _____

Employer Name _____ Occupation _____ Cell _____ Work _____

Employer Address _____ City/State/Zip _____

PERSON TO CONTACT IN CASE OF EMERGENCY (Other than parent)

Name _____ Relationship _____ Phone _____

INSURANCE - **Please provide insurance card to be copied. Please provide insurance card at all future visits.**

Subscriber's Name: _____ Subscriber's DOB: _____ _____

Relationship: _____ Subscriber's Employer: _____ ____

A copy of my insurance serves as valid proof of current insurance. I agree to notify and provide a copy of my insurance to KID-DOC Pediatrics upon any insurance changes that occur.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and other health plans to Shahzad A. Sheikh, M.D., P.A. dba KID-DOC Pediatrics. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to any parties necessary to secure payment and or to facilitate quality assurance. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I certify that the information I have provided with regard to my insurance coverage is correct. I have read and understand the HIPAA and Financial Policy in its entirety and agree to abide by ALL policies and procedures and be responsible for ALL charges and fees applicable to the services rendered at KID-DOC Pediatrics. I authorize being contacted by email/text for appointment reminders, balances, and or any notifications.

Signature: _____ **Date:** _____