

Kids Care Pediatrics
110 Baughman's Ln. Ste 150
Frederick, Md. 21702
(P) 301-696-8813 (F)301-696-8832

Date: _____

Registration Form

Patient Name: _____ DOB: _____ Sex: [] M [] F

Mother/Guardian: _____ DOB: _____ SS# _____

Address: _____ Home: _____

City/State/Zip: _____ Cell: _____

Employer: _____ Work: _____

Father/Guardian: _____ DOB: _____ SS# _____

Address: _____ Home: _____

City/State/Zip: _____ Cell: _____

Employer: _____ Work: _____

Sibling: _____ DOB: _____ Sibling: _____ DOB: _____

Sibling: _____ DOB: _____ Sibling: _____ DOB: _____

Children live with: Mother:[] Father:[] Guardian:[] **EMAIL:** _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Who Referred You To Our Office: _____

Insurance Information: Primary: _____ Claims Address: _____

Policy #: _____ Group #: _____ Co-Pay\$ _____

Name of Insured: _____ Relationship: _____

Secondary: _____ Claims Address: _____

Policy #: _____ Group #: _____ Co-Pay\$ _____

Name of Insured: _____ Relationship: _____

Authorization of Treatment and Assignment of Benefits: I authorize Kids Care Pediatrics to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Kids Care Pediatrics for all medical and surgical benefits otherwise payable under the terms of my insurance. I understand that I am financially responsible for all copayments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and as valid as the original. I understand that if my child's physician, or any other person employed by or under direction and control of my child's physician is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center of Disease Control, transmit Human Immunodeficiency Virus (HIV) or Hepatitis B or C viruses, that I am deemed by law to have consented to testing for the infection with HIV or Hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Parent/Guardian's Signature: _____ **Relationship:** _____