Patient Registration

Date: ___/___/___

Patient Name_____ **Sex: [ ] M [ ] F DOB**___/___/___**SS#**_____

Mother/Guardian_____ **DOB**___/___/___ **SS#**_____

Address_____ **Home Phone**_____

City/State/Zip_____ **Cell Phone**_____

Employer_____ **Work Phone**_____

Father/Guardian_____ **DOB**___/___/___ **SS#**_____

Address_____ **Home Phone**_____

City/State/Zip_____ **Cell Phone**_____

Employer_____ **Work Phone**_____

Sibling_____ **Sex: [ ] M [ ] F DOB**__/__/__ **Sibling**_____ **Sex: [ ] M [ ] F DOB**__/__/__

Sibling_____ **Sex: [ ] M [ ] F DOB**__/__/__ **Sibling**_____ **Sex: [ ] M [ ] F DOB**__/__/__

Sibling_____ **Sex: [ ] M [ ] F DOB**__/__/__ **Sibling**_____ **Sex: [ ] M [ ] F DOB**__/__/__

Sibling_____ **Sex: [ ] M [ ] F DOB**__/__/__ **Sibling**_____ **Sex: [ ] M [ ] F 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**_____

Kids Care Pediatrics
Roomika T. Baig, M.D.
801 Toll House Ave, Suite H6
Frederick, MD 21701
(P) 301-696-8813 (F) 301-696-8832

Authorization of Treatment and Assignment of Benefits

I authorize Roomika T. Baig, M.D., LLC to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Roomika T. Baig, M.D., LLC for all medical or surgical benefits otherwise payable to me 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 the 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 for Disease Control, transmit the Human Immunodeficiency Virus (HIV) or Hepatitis B or C viruses, that I am deemed by law to have consented to testing for 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**_____ **Date** ___/___/___