TERRA LINDA PEDIATRICS, INC

PEDIATRIC PATIENT REGISTRATION FORM/ PERMISSION TO TREAT

Primary Language :_________________ **Race/Ethnicity** _______________ **Date**___________

Mother's Name:___________________________________ **Father's Name**____
Last First DOB *Last First DOB*

Mother's Address _________________________________ **Father's Address** _____________________________________

_________________________________ _____________________________________

Primary Phone # ___________________________ **Primary Phone #** ___________________________

Secondary Phone # _________________________ **Secondary Phone #**_________________________

Child 1 Name: _____________________________________ **Child 2 Name** ____
Last (if different) First DOB *Last (if different) First DOB*

Child 3 Name: _____________________________________ **Child 4 Name** ____
Last (if different) First DOB *Last (if different) First DOB*

Employer:_______________________________________ **Work #**:_____________ **Email** : _____________________________

How were you referred to this office?:____

Emergency Contact:____ **Phone #**:___________________________

Primary Insurance:____**Physician**:___________________________________

Group #:___________________**ID #**:______________________________

Subscriber's Name:_____________________________**DOB**___________ **M / F** **Marital Status**__________

Subscriber's Address _______________________________ **Primary phone #** ___________________

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4. PATIENT'S INSURANCE INFORMATION (Please present insurance card for photocopying)

ASSIGNMENT: I hereby assign my insurance benefits to be paid directly to Terra Linda Pediatrics, Inc./ Dr.Yamaguchi. I understand that I am financially responsible for any and all non-covered services.
RELEASE: I authorize Terra Linda Pediatrics Inc./ Dr. Yamaguchi to release to my insurance carriers any information required to process my claims.

I, the undersigned, hereby agree that in the event of default in the payment of any amount due, and if this account is placed in the hands of an agency or attorney for collection or legal action, to pay an additional charge equal to the cost of collection including agency and attorney fees and court costs incurred as permitted by laws governing these transactions.

It is further understood, if any appointments are missed without 24 hour cancellation notice, a $ 50 fee will be charged, as well as the following charges that may be incurred

- Returned checks $25.
- Consultations $ 125.
- Non-covered vaccines.
- Release of medical records $15./chart

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Parent or Guardian Date