GLENS FALLS PEDIATRIC CONSULTANTS
PATIENT REGISTRATION

Date _____

Patient's Name: _____ Sex: ***M/F*** (Circle) DOB _____
First Middle Initial Last

Primary Doctor: _____ Primary Language: _____ Race: _____ Ethnic Origin: _____

Pharmacy of Choice: _____
Name Street City State Zip

Patient's Address: _____
Street City State Zip

Email Address: _____
(Please provide if willing to be contacted by email)

Mother's Name: _____ DOB _____ SS# _____

Address: _____
Street City State Zip

Phone #: (Home) _____ (Work) _____ (Cell) _____

Occupation: _____ Employer: _____

Mother's Maiden Name: _____

Father's Name: _____ DOB _____ SS# _____

Address: _____
Street City State Zip

Phone #: (Home) _____ (Work) _____ (Cell) _____

Occupation: _____ Employer: _____

Name of Primary Insurance: _____

Subscriber's Name: _____ Subscriber's DOB _____ Subscriber's SS# _____

Address _____

Name of Secondary Insurance: _____

Subscriber's Name _____ Subscriber's DOB _____ Subscriber's SS# _____

Address _____

RESPONSIBLE PARTY (Person to Receive Billing Statements):

Name: _____

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I authorize Glens Falls Pediatric Consultants to use or disclose my personal health information (PHI) to treat my condition, Obtain payment for that treatment, and run the business operation. I also give my permission to disclose my personal Health information (PHI) for payment activities and certain business operations of another healthcare provider or payor.
*****In the event that my insurance carrier does not pay, I agree to be financially responsible for any debts incurred.*****

Signature: _____ Date _____
Parent or Legal Guardian