GLENS FALLS PEDIATRIC CONSULTANTS
PATIENT REGISTRATION

Date: _____

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

Primary Doctor:_____ Primary Language:_____ Ethnic Race :_____Origin:_____

Pharmacy of Choice:_____
Name Street City State Zip

Patient's Address**:**_____
Street City State Zip

Email Address:_____

Mother's Name: _____ DOB: _____
or Legal Guardian: _____ Relationship to Patient: _____

Address:_____
Street City State Zip
Phone # (Home): _____ (Work): _____ (Cell): _____

Occupation: _____ Employer: _____
Maiden Name: _____

Father's Name: _____ DOB: _____
or Legal Guardian: _____ Relationship to Patient: _____

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:_____

<u>Responsible Party</u> (Person to Receive Billing Statements): _____

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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 payer. In the event that my insurance carrier does not pay, I agree to be financially responsible for any debts incurred.

Signature:_____**Date:**_____