



THE PEDIATRIC CENTER OF FREDERICK. L.L.C.

1475 TANEY AVE • FREDERICK, MD 21702 • 301-662-0133

PATIENT REGISTRATION				DATE
Patient's Name:		SSN:	Birth Date:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Address:				
City:	State:	Zip:	Home Phone:	
Father's Name:		SSN:	Home Phone:	
Address:	City:	State:	Zip:	Work Phone:
Employer:	How Long Employed:		Cell Phone #:	
Employer Address:		Occupation:	E-mail Address:	
City:	State:	Zip:	Family Religion:	
Mother's Name:		SSN:	Home Phone:	
Address:	City:	State:	Zip:	Work Phone:
Employer:	How Long Employed:		Cell Phone #:	
Employer Address:		Occupation:	E-mail Address:	
Nearest Friend or Relative (Not Living with Patient):				
Home Phone:		Relationship to Patient:		
PRIMARY INSURANCE		Co-payment	SECONDARY INSURANCE	
Name of Company:			Name of Company:	
Address:			Address:	
Policy/ID#:			Policy/ID#:	
Group#	Phone:		Group#	Phone:
Insured's Name:			Insured's Name:	
FAMILY HISTORY				
Family Members		Birth Date	Health Problems	
Father:				
Mother:				
Siblings:				
Problem	Relationship to Patient	Problem	Relationship to Patient	
Diabetes:		Cancer:		
Heart:		Kidney:		
Seizures:		Genetic:		
Anemia:		Allergies:		
PATIENT HISTORY				
Problems During Pregnancy:		In the Nursery:		
During Delivery:		During 1st week of life:		
Operations:				
Significant Illnesses:				
Allergies:				

RESPONSIBLE PARTY

THE POLICY IN OUR OFFICE IS THE PATIENT WHO REQUESTS TREATMENT FOR THE CHILD IS RESPONSIBLE FOR ALL FEES FOR SERVICES RENDERED.

I realize verification of insurance coverage is my responsibility. In the event that the listed medical service is not covered by my insurance, I agree to be financially responsible for the charges for these services.

If my account is assigned to a collection agency, I agree to pay all agency fees, court costs, and attorney fees. I understand that all accounts with a balance over 30 days will be assessed a 1.5% late charge per month on the unpaid monthly patient balance.

I do hereby authorize The Pediatric Center of Frederick, LLC, to apply for benefits on my behalf for services rendered. I request payment to be made directly to The Pediatric Center. I verify the information reported regarding my coverage is correct and further authorize the release of any necessary information for any claim to my insurance company.

Today's Date

Signature of Patient, Parent or Responsible Party