DOVER PEDIATRICS, PLLC — PEDIATRIC REGISTRATION FORM

Your insurance card & proof of identity such as a driver's license are required in order to bill your insurance for services. If you do not have these at your visit, please be prepared to pay for services rendered at the time of service.

PATIENT INFORMATION

Today's Date: _____

First Name | Middle | Last Name | Nickname

Date of Birth | Sex | Home Phone Number ( ) | Cell Phone Number ( )

Patient Address (Street, Route, Apt., Etc.) | City | State | Zip Code

Mailing Address (if different) | City | State | Zip Code

Current/ Previous Physician's Name | Current/Previous Physician's Office Number

INSURANCE INFORMATION

Primary Insurance Company Name | Policy Number | Group/Plan Number

Cardholders Name | Date of Birth | Effective Date of Coverage

Secondary Insurance Company Name | Policy Number | Group/Plan Number

Cardholders Name | Date of Birth | Effective Date of Coverage

☐ *I certify that I or my dependent above have insurance coverage as indicated above and assign directly to Dover Pediatrics all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions as well as to release information necessary for the payment of claims.*

PARENT/GUARDIAN INFORMATION

Mother's Name

Mother's social security number | DOB

Spouse's Name

Address, City, St., Zip

Home Phone Number ( )

Cell Phone Number ( )

Employer's Name

Work Phone Number ( )

Father's Name

Father's social security number | DOB

Spouse's Name

Address, City, St., Zip

Home Phone Number ( )

Cell Phone Number ( )

Employer's Name

Work Phone Number ( )

☐ ***Scanned in EHR*** ☐ ***Staff Initials:*** _____