Child's Registration Form

Today's date	Child's name Last First M.I. SEX ❑ M ❑ F	Date of Birth

Street Address	City, State	Zip

Home ( ) Telephone Area code	Child's SS#

Mother/Guardian Name	Date of Birth	SS#	Telephone Work Home
Occupation	Employer		Mobile

Father/Guardian Name	Date of Birth	SS#	Telephone Work Home
Occupation	Employer		Mobile

Child's Siblings

Name Last First M.I.	Date of Birth

Insurance Information

Co-pay required prior to service rendered

Primary Insurance Company	Effective date	Co-pay
Claim address	Telephone	Group #
		ID#

Name of Insured	Relationship to Patient

Contacts

Referred by	Address	Telephone
Closest Relative (not at your address)		
Emergency (other than child's parents)		

Please complete reverse side of this document

Billing information

Payment required at the time service rendered unless prior arrangements made

Name of Individual		Relationship to Child
Street Address	City, State	Zip

Assignment of insurance benefits and Authorization to release information

I hereby authorize payment of healthcare benefits to **Clinical Pediatric Associates of North Texas** for the services rendered by any person under the physician's supervision. I understand that I am financially responsible for any balance not covered by my insurance carrier. I also authorize **Clinical Pediatric Associates of North Texas** to release any medical information or incidental information that may be necessary for either medical care or processing applications for financial benefit.

Child's name printed	Parent/Guardian name printed
Date signed	Parent/Guardian signature

Thank you for selecting us to partner in your child's healthcare