South Summit Pediatrics-
Patient Registration

Patient(s) Name (Please put all your children who are seen here)	Date of Birth	Sex (circle)	Account # (office use only)
1.		M F	
2.		M F	
3.		M F	
4.		M F	
5.		M F	
6.		M F	

Address:		
Email Address:		
Primary Phone Number:	**Secondary Phone Number:**	
Parent #1 Name:	**Date of Birth:**	
Parent #2 Name:	**Date of Birth:**	
Emergency Contact:	**Relation:**	**Phone Number:**

I authorize South Summit Pediatrics to use and/or disclose certain protected medical information about my child(ren) to/or for the parties listed below. This authorization permits the following people to make medical decisions, and schedule appointments on my behalf:

Name:	Date of Birth:

By signing this authorization, I acknowledge the above and I have been given a copy of South Summit Pediatrics HIPAA Policy and The Notice of Privacy Practice.

Responsible Party Signature:_____ **Date:**_____

Insurance Information (Proof of insurance is required)		
Primary Insurance Name:		
Policy Holder:	**Date of Birth:**	**Relation:**
ID/Subscriber #:		
Employer:	**Work Phone:**	
Secondary Insurance Name:		
Policy Holder:	**Date of Birth:**	**Relation:**
ID/Subscriber #:		
Employer:	**Work Phone:**	

By signing below, I understand it is my responsibility to make sure my child's insurance is correct at the time of service, especially if the patient has double coverage. Failure to properly notify the clinic will result in $25.00 per claims reprocessing fee for any necessary claim resubmission to the proper primary/secondary insurance. For claims that have been denied due to untimely filing, passing the 90-day submission window from the date of service, you would be responsible for full balance for that date of service.

Responsible Party Signature:_____ **Date:**_____