PATIENT REGISTRATION FORM

PREMIER PEDIATRICS, INC.
1606 Prairie Center Parkway, #300
Brighton, CO 80601
Phone 303-655-1685
Fax 866-926-6081

Patient Information

Last Name: _____ First Name: _____ Middle Name: _____
Sex: _____ Date of Birth: _____ Social Security No.: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: ( ) _____ - _____ Work Phone: : ( ) _____ - _____ Mobile Phone: ( ) _____ - _____
Marital Status:_____

Guarantor Information (to whom the statements will be sent)

Last Name: _____ First Name: _____ Middle Name: _____
Sex: _____ Date of Birth: _____ Social Security No.: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: ( ) _____ - _____ Work Phone: : ( ) _____ - _____ Mobile Phone: ( ) _____ - _____
Employer Name: _____ Employer Phone: _____
Marital Status: _____

Primary Insurance Information

Insurance Plan Name: _____
Address to Send Claims: _____
Insurance Phone Number: **( )** _____-_____

Policy Information

Patient's relationship to policy holder: _____
ID No.: _____ Policy/Group No.: _____
Issue Date: _____ Exp Date: _____
Copay Amount: _____ Co-insurance Percent: _____

Primary Insurance Policy Holder Information

Last Name: _____ First Name: _____ Middle Name: _____
Sex: _____ Date of Birth: _____ Social Security No.: _____
Employer Name: _____ Employer Phone: _____

Secondary Insurance Information

Insurance Plan Name: _____
Address to Send Claims: _____
Insurance Phone Number: **( )** _____-_____

Policy Information

Patient's relationship to policy holder: _____
ID No.: _____ Policy/Group No.: _____
Issue Date: _____ Exp Date: _____
Copay Amount: _____ Co-insurance Percent: _____

Secondary Insurance Policy Holder Information

Last Name: _____ First Name: _____ Middle Name: _____
Sex: _____ Date of Birth: _____ Social Security No.: _____
Employer Name: _____ Employer Phone: _____

ASSIGNMENT AND RELEASE:

- I hereby assign my insurance benefits to be paid directly to the physician.
- I understand that I am financially responsible for all non-covered services including missed appointment fees.
- I authorize the physician to release any information required to process this claim

_____ _____
Signature Date

PLEASE BRING YOUR INSURANCE CARD TO YOUR APPOINTMENT