REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's Last Name:	First:	Email:	Home phone no.:

Is this your legal name?		If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:	
❑ Yes	❑ No			/ /		❑ M	❑ F

Street address:	City:	State:	ZIP Code:

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.		❑ Insurance Plan	❑ Hospital
❑ Family		❑ Friend	❑ Close to home/work		❑ Other

Other family members seen here:	

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
	/ /		( )

Occupation:	Employer:	Employer address:	Employer phone no.:
			( )

Is this patient covered by insurance?	❑ Yes	❑ No	

Please indicate primary insurance	❑ Aetna	❑ BCBS PPO	❑ BCBS Blue Choice	❑ Cigna	❑ Humana ❑ UHC ❑ Medicare
❑ Medicaid	❑ BlueCross Community	❑ IlliniCare Health	❑ Meridian Health	❑ Molina Healthcare	❑ YouthCare ❑ Other_____

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
		/ /			$

Patient's relationship to subscriber:	❑ Self	❑ Child	❑ Other	

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Thrive Pediatrics or insurance company to release any information required to process my claims.

Patient/Guardian signature	*Date*

Patient Name_____ Date of Birth_____