MOUNTAIN VIEW PEDIATRICS, P.A.
PATIENT REGISTRATION SHEET

Date_________________ **Patient Number**_________________

Child's Name_________________ Date of Birth_________________
Mailing Address_________________ Zip Code_________________
SS#_________________ Name Used or Nickname _________________ Sex: M_____F_____

Father's Full Name_________________ Phone _________________
SS#:_________________ Date of Birth_________________
Mailing Address (if different than child)_________________ Zip Code_________________
Employer _________________Phone #_________________
Insurance Coverage with this employer for child? Yes_____ No_____ Cell Phone #_________________
If Yes, Name of Insurance Company_________________

Mother's Full Name_________________ Maiden Name_________________
SS#: _________________Date of Birth_________________ Phone #_________________
Mailing Address (if different than child)_________________ Zip Code_________________
Employer _________________Phone #_________________
Insurance Coverage with this employer for child? Yes_____ No_____ Cell Phone #_________________
If Yes, Name of Insurance Company_________________

Other Insurance Coverage (Medicaid, NC Health Choice, etc.)_________________

Emergency Contact #1_________________Relationship_____________Phone_________________
Emergency Contact #2_________________Relationship_____________Phone_________________

Other Family Members who are Patients at Mountain View Pediatrics:
Full Name _________________DOB _________________
Full Name _________________DOB _________________
Full Name _________________DOB _________________
Full Name _________________DOB _________________

CONSENT FOR TREATMENT AND PAYMENT PROCEDURES
PLEASE READ THIS SECTION CAREFULLY!!!

I give permission for physicians of Mountain View Pediatrics, P.A. or persons designated by them, to interview, examine, and perform necessary laboratory/radiological procedures and to provide appropriate treatment to the above named minor. Permission for evaluation and treatment granted whether child presented by parent, other family member, unrelated third party, or unaccompanied.

Signed:_________________Relationship_________________Date_________________

I hereby authorize Mountain View Pediatrics, P.A. to furnish any necessary information concerning my child, _________________ to my insurance carriers, to other medical personnel to whom physicians of Mountain View Pediatrics have referred my child for treatment, and to the admitting hospital should my child be admitted for treatment.

Signed:_________________Relationship_________________Date_________________

I understand that all professional charges are charged to the patient. Payment for these services is due at the time of service. Patients covered under a contracted insurance plan are required to pay any co-payment, deductible or coinsurance at the time of service. Patients covered under non-contracted insurance plans are responsible for filing all office charges with the insurance carriers with the information we provide for that purpose. **NOTE:** Divorce has no bearing on the responsibility for medical care as it affects third parties. **Whoever brings the child is expected to pay the charges due for the service rendered that day.** Mountain View Pediatrics does not get involved in payment disputes between parents. I understand that insurance/Medicaid cards should be presented at every visit.

Signed:_________________Relationship_________________Date_________________

DATE **Changes in above information (i.e., new address, phone #), or explanation (i.e., "parent separation, "child living with grandmother," etc.)**
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RETURN THIS COMPLETED FORM TO THE RECEPTIONIST ALONG WITH CURRENT INSURANCE AND MEDICAID CARDS – THANK YOU!