

**PEDIATRIC PATIENT REGISTRATION FORM:**

Patient's (child) Name: \_\_\_\_\_ Home Phone#: \_\_\_\_\_  
Last First Middle  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient Social Security#: \_\_\_\_\_ Patient's Sex: Male Female

Patient Date of Birth: \_\_\_\_\_

**Parent Information:**

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_  
Home address: \_\_\_\_\_ Home address: \_\_\_\_\_  
Cell phone #: \_\_\_\_\_ Cell phone #: \_\_\_\_\_  
Email address: \_\_\_\_\_ Email address: \_\_\_\_\_  
Mother's birth date: \_\_\_\_\_ Father's birth date: \_\_\_\_\_  
Employer's Name: \_\_\_\_\_ Employer's Name: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_ Employer's Address: \_\_\_\_\_  
Work Number: \_\_\_\_\_ Work Number: \_\_\_\_\_

If parents are divorced/separated is there a court order or other financial arrangement we need to be aware of?

\_\_\_\_\_ Name of step parent: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone#: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Pediatrician Name:** \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone # \_\_\_\_\_

**Referring Doctor** (if different from Pediatrician) \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone #: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Town: \_\_\_\_\_ Phone #: \_\_\_\_\_

**INSURANCE INFORMATION** (Must be completed in full so that we may submit to your insurance for reimbursement.)

**Primary Insurance:** \_\_\_\_\_

Policyholder's name (insured's name): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex: Male Female Social Security #: \_\_\_\_\_ Employer: \_\_\_\_\_

Patient's relationship to insured (please select): Child Other/ Dependent

Group Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

Policyholder's name (insured's name): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex: Male Female Social Security #: \_\_\_\_\_ Employer: \_\_\_\_\_

Patient's relationship to insured (please circle): Child Other/ Dependent

Group Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

I request that payment of authorized Medicare, Medicaid, and/or commercial insurance benefits be made to Garden State Urology for any service furnished to me by GSU's physicians. I authorize Garden State Urology to release medical information which may be required by my insurance carrier to determine payment for services rendered. I further understand that I am responsible to pay certain amounts due the physician. These amounts could include annual deductibles, co-payments, charges denied as not covered by Medicare or my insurance program, and charges denied for services determined as not medically necessary. I further understand that if GSU incurs any fees associated with collecting reimbursement on my account, I will be responsible for paying those fees.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_