ACCOUNT #:_____

Pediatric Specialists of Pendleton, LLC Patient Registration

Patient Information

Patient's Physician: _____ **Primary Pharmacy**:_____

Patient Name: **Last:** _____ **First:** _____ Middle: _____

Date of Birth: _____ Sex: _____ SSN: _____ Race: _____

P O Box & Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Primary Phone: _____

Email Address: _____

Parents / Guardians □ **Check here if address and phone are the same as the patient (complete name, dob, employer, work #)**

Last Name: _____ **First:** _____ Middle: _____

Relationship: Mom Dad Step Mom Step Dad Foster Mom Foster Dad Other_____

Address: _____ Date of Birth: _____ SSN: _____

Employer: _____ Home Phone: _____ Work Phone: _____

Last Name: _____ **First:** _____ Middle: _____

Relationship: Mom Dad Step Mom Step Dad Foster Mom Foster Dad Other_____

Address: _____ Date of Birth: _____ SSN: _____

Employer: _____ Home Phone: _____ Work Phone: _____

Emergency Contact **Last** Name: _____ **First:** _____
(Someone living outside the home)
Home phone: _____ Cell: _____ Work Phone: _____

Insurance Information

Primary Company: _____ Co Pay $ _____

Insured Name: _____ DOB: _____ SSN: _____

ID# _____ Group # _____

Secondary Company: _____ Co Pay $ _____

Insured Name: _____ DOB: _____ SSN: _____

ID # _____ Group # _____

Assignment & Release: *I hereby authorize my insurance benefits to be paid directly to Pediatric Specialists of Pendleton, LLC and I am financially responsible for all service rendered whether covered or not thru my insurance plan. I also authorize PSP, LLC to release any information required in processing any claims.*

Signature:_____ Date:_____

Reviewed (sign):_____ Date:_____