Brighton Pediatric Center
Registration Form

PATIENTS INFORMATION
(Please list all children we will be caring for)

Last Name	First Name	MI	M/ F	DOB	Chart #
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				/ /	
				/ /	
				/ /	
				/ /	
				/ /	
				/ /	

PARENTS INFORMATION

Home Street Address		City State Zip		Phone ( ) -
Father's Name	Occupation/ Employer	DOB / /	CELL PHONE ( ) -	SSN (last 4 digit) XXX - XX -
Mother's Name	Occupation/ Employer	DOB / /	CELL PHONE ( ) -	SSN (last 4 digit) XXX - XX -
Guardian's Name	Occupation/ Employer	DOB / /	CELL PHONE ( ) -	SSN (last 4 digit) XXX - XX -
Emergency Contact (Other than Parents)		Relationship		Phone ( ) -

INSURANCE & BILLING INFORMATION

Person Financially Responsible: ☐ Father ☐ Mother ☐ Other Relationship:

PRIMARY INSURANCE:	SECONDARY INSURANCE:
Subscriber's Name	Subscriber's Name
Insurance ID	Insurance ID
Group # /or Name of Employer	Group # /or Name of Employer
Effective Date	Effective Date
Address	Address

PAYMENT REQUIRED AT TIME OF SERVICE- UNLESS PRIOR ARRANGEMENT HAS BEEN MADE

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform Brighton Pediatric Center of any changes in my minor's/ child's medical status. Insurance status, and / or financial status. Additionally, I will inform Brighton Pediatric Center of any address changes that may affect billing.

I certified that my minor/ child is covered by the above insurance company/ companies, and I assign directly to Brighton Pediatric Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Brighton Pediatric Center, and doctors associated with Brighton Pediatric Center to release all information necessary to process a claim. I authorize the use of this signature on all my submissions, whether manual or electronic. *A photocopy of these assignments shall be as valid as the original*

Signature_____ Date_____/_____/_____

HOW DID YOU HEAR ABOUT US

☐ Friend/ Relative_____ ☐ Hospital_____ ☐ Yellow Pages_____
☐ Another Physician_____ ☐ Insurance Co_____ ☐ Internet_____
☐ Other_____