PATIENT REGISTRATION

Legacy Pediatrics 107 Contempo Ave. Ste. 2 West Monroe, LA 71291

Patient's Name_____(_____)
First Middle Last Preferred

DOB:_____ Sex: M F SS#_____ Race:_____
Person child lives with:_____ Relationship:_____
Address:_____City:_____State____Zip_____
Siblings:_____ _____
_____ _____
_____ _____

Mom's (or Guardian's):
Full Name:_____ Home phone:_____
Address:_____ Work phone:_____
City:_____State_____Zip_____ Cell phone:_____
SS#_____Birthdate_____ E-mail:_____
Employer:_____

Dad's (or Guardian's):
Full Name:_____ Home phone:_____
Address:_____ Work phone:_____
City:_____State_____Zip_____ Cell phone:_____
SS#_____Birthdate_____ E-mail:_____
Employer:_____

Person to contact in case of emergency (other than parents):_____
Relationship: _____ Phone:_____

PREFERRED PHARMACY: _____ PHONE:_____

Insurance information:

Company:_____Group No:_____
Subscriber ID:_____Co-pay:_____Ded. Amount:_____
Insured Name:_____ DOB_____ SSN:_____
Employer:_____

Payment is due at the time services are rendered. This includes applicable coinsurance and copayments for participating insurance companies. We file primary insurance only!

✔ I hereby authorize Legacy Pediatrics to furnish information to any insurance carrier carrier, physician, attorney or employer concerning my child's medical history, illness and treatment and hereby assign to the physician(s) all payments for medical services rendered to my dependants or myself. I also authorize any physician, hospital insurance carrier or employer to release any information concerning my child's medical history, illness and medical treatments to Legacy Pediatrics.

€ I have received a copy of *Legacy Pediatrics* Notice of Privacy Practices.

€ I consent to medical treatment necessary for the above patient.

_____ _____
Signature of legal guardian/relationship Date