JUDE BARES, MD.

Pediatrics and Adolescent Medicine

PATIENT REGISTRATION FORM

Please Print

PATIENT NUMBER:_____ M:_____ F:_____ BIRTHDAY:_____

LAST NAME:_____ FIRST:_____ MI:_____ PREFERRED NAME:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

HOME PHONE:_____ CELL PHONE:_____ REFERRED BY:_____

MOTHER'S NAME:_____ OCCUPATION:_____

EMPLOYER:_____ WORK PHONE:_____

MOTHER'S SS#:_____ FATHER'S SS#:_____

FATHER'S NAME:_____ OCCUPATION:_____

EMPLOYER:_____ WORK PHONE:_____

DOES YOUR INSURANCE COMPANY REQUIRE PRECERTIFICATION: Yes or No

Email:_____

GUARANTOR INFORMATION

RESPONSIBLE PARTY'S LAST NAME:_____ FIRST:_____ MI:_____

DOB:_____ RELATIONSHIP:_____ PHONE:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

RESPONSIBLE PARTY'S SS#:_____

RESPONSIBLE PARTY'S EMPLOYER:_____ OCCUPATION:_____

EMPLOYER'S ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

PRIMARY INSURANCE COMPANY:_____ PHONE:_____

COMPANY ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

POLICY HOLDER'S LAST NAME:_____ FIRST:_____ MI:_____

RELATIONSHIP:_____

CERTIFICATE NO.:_____ GROUP NO.:_____ MEMBER NO.:_____

SECONDARY INSURANCE COMPANY:_____ PHONE:_____

COMPANY ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

POLICY HOLDER'S LAST NAME:_____ FIRST:_____ MI:_____

RELATIONSHIP:_____

CERTIFICATE NO.:_____ GROUP NO.:_____ MEMBER NO.:_____

OTHER CHILDREN SEEN BY DR. BARES:_____

EMERGENCY CONTACT
(other than parent)

NAME:_____ PHONE:_____ RELATIONSHIP:_____

AGREEMENT OF PROFESSIONAL SERVICES: I agree that the determination of professional services to be rendered by my physician are a matter concerning my physician and myself. I understand that I am responsible for payment of these fees regardless of insurance benefits. Neither my physician nor myself will permit a third party to determine what medical services need or what less that my physician should charge for these services. I also agree that in the event my account becomes delinquent, I am responsible for all costs incurred in the collection of my account if referred to any outside agency.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: This form authorizes Dr. Jude Bares to release confidential information in regards to my professional medical care to identifiable persons associated with my insurance company. This information must be released in writing only. No information may be legally released over the telephone.

ASSIGNMENT AGREEMENT: I hereby assign, convey, and transfer all of my rights which exist under my contract of health insurance for reimbursement of medical benefits to the physician or supplier for the services described in block 13 of the claim form. In addition to authorization for payment for such medical benefits. I also assign, convey, and transfer to my physician any and all rights which I have under my health insurance contract and/or which to legal and judicial enforcement or this claim, as well as for penalties, cost of services for collection, and attorney's fees resulting from the failure to satisfy this claim within the time allowed by law.

Date:_____ Signature:_____
(Patient or Responsible Party)