New Patient Registration Information

Model City Pediatrics

Tatiana Bidikov

1300 Leighton Ave Anniston, AL 36207

Date_____

Patients Name: _____Sex: __ M__ F

Race: _____ Ethnicity: _____ Preferred Language: _____

Date of Birth: _____ Social Security #: _____

Phone: _____Cell: _____ Email Address: _____

Address: _____City: _____ Zip: _____

Father's Name: _____ Employer: _____

Date of Birth: _____SS#: _____ Work # _____

Address: _____ City: _____ Zip: _____

Mother's Name: _____ Employer: _____

Date of Birth: _____ SS#:_____ Work #:_____

Address: _____ City: _____ Zip: _____

NAME OF PERSON RESPONSIBLE FOR BILL: _____

Address: _____

Employer: _____

Phone: _____

Insurance Information

Name of Company Subscribers Name Policy & Group #

1._____

2_____

List Names of All Siblings

Name DOB

1._____

2. _____

3._____

4._____

5._____

I understand that regardless of insurance coverage, I am responsible for my account, and my account is to be paid in full within 30 days. I also understand that if this account is referred to a collection agency that I will pay all costs of collection and enforcement, including reasonable service fees.

_____

Signature

I authorize the following persons to present my child to Model City Pediatrics for medical care in my absence, and to sign for immunizations. I give Model City Pediatrics permission to treat any and all medical conditions during this and subsequent visits.

_____
_____
_____
_____
_____
_____

Signature: _____ Date: _____