Registration/Insurance Form

Baby's Last Name_____ First Name_____ Middle Initial_____ Date of Birth_____

Referred by_____

PARENT INFORMATION

Name_____ Date of Birth_____

Street Address_____ Apt/Unit #_____

City_____ State_____ Zip Code_____

Social Security Number_____ Driver's Lic #_____ Marital Status: S M W Sep D

Telephone: Home_____ Cell_____ Office_____

Employer Name_____ Tel #_____

City_____ State_____ Zip Code_____

ADDITIONAL PARENT

Name_____ Date of Birth_____

Street Address_____ Apt/Unit #_____

City_____ State_____ Zip Code_____

Social Security Number_____ Driver's Lic #_____ Marital Status: S M W Sep D

Telephone: Home_____ Cell_____ Office_____

Employer Name_____ Tel #_____

City_____ State_____ Zip Code_____

INSURANCE

Medicaid # (if applicable)_____ Medicare # (if applicable)_____

Primary Insurance Company Name_____

ID #_____ Group #_____ Tel #_____

Secondary Insurance Company Name_____

ID #_____ Group #_____ Tel #_____

MEDICAL INFORMATION RELEASE AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date_____ Signature_____
(Parent or guardian)

I hereby authorize Dr. Ronald Buckman to apply for benefits on my behalf for covered services rendered by him. I request that payment from my insurance company be made directly to Dr. Ronald Buckman or Family Medicine Partnership, PC DBA Bolton Family & Sports Medcine.

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date _____ Signature_____
(Parent or guardian)