HEALTHY START PEDIATRICS

525 South Drive, Suite 201, Mountain View, CA 94040. Phone: (650) 968-8891. Fax: (650) 968-8822.

PATIENT REGISTRATION FORM

(The information below is important. Please be complete and accurate.)

Child's Name: ____Gender (M/F):___________

First Middle Last

Date of Birth: __________/______________/__________Home Tel: __(________)___________________________

Address:____

Street City State Zip Code

Mother's Name: ____Date of Birth: _______/_________/_______

Mother's SSN:______________________________Mother's Phone:(Cell)_____________________________________

Mother's Address (if different from above): ____

Father's Name: ____Date of Birth:_________________________

Father's SSN:______________________________ Father's Phone:(Cell)___________________________________

Father's Address (if different from above): ____

Emergency Contact: Name: ______________________________________Phone No:___________________________

The child listed above is covered by the following insurance(s):

Primary Insurance: ____ID #: ___________________________________

Insured's Name: ____Relationship to Patient: ____________________

Secondary Insurance: ____ID #: __________________________________

Insured's Name: ____Relationship to Patient: ____________________

AUTHORIZATION

I authorize Healthy Start Pediatrics to:

- Provide medical care for the patient.
- File claims with my insurance company on my behalf for medical benefits for all services provided.
- Release medical information by written or electronic means to my medical benefits plan as may be necessary to process my benefits claims.

I understand that all copayments, deductible amounts and/or non-covered medical services are due at the time of service. Any unpaid balance not paid by insurance company within 60 days of filing the claim are my responsibility, and are due payable in 30 days after insurance company's denial or 60 days of non-payment.

Signature of Parent/Guarantor ____ Date: _______/________/_____