Minor Patient Registration Form

Patient Information:

Name: _____ Date of Birth: ____/____/_____
First Middle Last

Gender: _____ Referring Physician: _____

Home Address: _____
Street # Street Name Apt #

_____
City State Zip

Parent/Legal Guardian Information:

Name: _____ Date of Birth: ____/____/_____
First Middle Last

Employer: _____
Name Address

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security Number: _____ Relationship to child _____

** PLEASE PRESENT INSURANCE CARDS AND PHOTO ID TO RECEPTIONIST**

Payment is due at the time service rendered for co-pays, deductibles, co-insurance amounts and any other services or treatment not reimbursed by your insurance. We accept cash, personal checks, Visa, MasterCard, and Discover. Returned checks will incur a service charge of $25.00 or 5%, whichever is greater, as dictated by Florida law. Accounts with balances are due within 30 days of our statement to avoid a $25.00 rebilling fee. You will be responsible for any collection agency fees.

This office has provided its Notice of Privacy Practices for me to review.

My signature authorizes this office to release information for treatment, payment and health care operations and certifies that I have read and understand the financial policies set forth.

Do we have permission to:

Leave a message on your answering machine at home? □Yes □ No
Leave a message at your place of employment? □Yes □ No
Discuss your medical condition with family member? □Yes □ No
If yes, please give name: _____Relationship to you: _____

_____ Date: _____
Signature of parent or legal guardian