



Home Office:  Allentown  Coopersburg  
 Pond Road  Trexlertown  
 Laurys Station

## REGISTRATION FORM

Today's Date \_\_\_\_\_  
 Child's Full Legal Name \_\_\_\_\_ Gender M F  
 Birthdate \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Address \_\_\_\_\_  
 Telephone \_\_\_\_\_

Father's Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Address \_\_\_\_\_  
 Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Mother's Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Address \_\_\_\_\_  
 Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_

### RESPONSIBLE PARTY IF OTHER THAN PARENT LISTED ABOVE

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Home Phone # \_\_\_\_\_  
 Employer \_\_\_\_\_ Work Phone # \_\_\_\_\_

## MEDICAL INSURANCE

Primary Insurance _____	Secondary Insurance _____
Subscriber _____	Subscriber _____
ID or Policy # _____	ID or Policy # _____
Group # _____ Plan # _____	Group # _____ Plan # _____
Effective Date _____	Effective Date _____

### Brothers/Sisters

Name _____	Birthdate _____	Social Security # _____	M F
Name _____	Birthdate _____	Social Security # _____	M F
Name _____	Birthdate _____	Social Security # _____	M F

All professional services rendered are charged to the parent. Payment is due at time of service unless it is covered by an insurance in which we participate.

I hereby authorize ABC Family Pediatricians to furnish information to insurance carriers concerning my child's illness and treatments. I also authorize any insurance payment due to the physicians/providers to be paid directly to ABC Family Pediatricians.

I understand that I am responsible for any amount not covered by insurance.

Date: \_\_\_\_\_ Parent's Signature: \_\_\_\_\_

(over)



To Whom It May Concern,

I, \_\_\_\_\_ father / mother of \_\_\_\_\_  
children(s) name(s)

do hereby give consent to ABC Family Pediatricians for the period of 1/1/06 until the end of the current year to consent for any and all treatment including but not limited to medical, dental, and surgical that may be necessary for my child(ren).

Insurance:

Allergies:

Any medical conditions:

Child's Physician:

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_