Faith Pediatrics and Adolescent Medicine
Registration Information

Today's Date: _____

First name: _____ MI: _____ Last name: _____

Birth date:___/___/___ Age:____ Sex: ____ Social Security:_____-____-_____

Street Address:_____ Home Phone no.:( )_____

City:_____ State:_____ ZIP Code:_____

How Long have you lived at this address:_____ Email Address:_____

Parent Information

Mother's last name:_____ First name:_____ MI:____

Birthdate:___/___/____

Social Security Number:_____-____-_____ Address:(if different) _____

Father's Last name:_____ First name:_____ MI:____

Birthdate: ___/___/____

Social Security Number: _____-___-_____ Address: (if different) _____

Insurance Information

Primary Insurance:(please check one) Medicaid__ BCBS__ Cigna__ Aetna ___

United Heathcare __ Tricare__ MedCost ___ PCHS__ BCBS Health Choice___ Other__

Group Number #_____ Policy Number#_____ Co-Pay_____

Secondary Insurance: (please check one) Medicaid__ BCBS___ Cigna__ Aetna___

United Heathcare ___Tricare___ MedCost___ PCHS__ BCBS Health Choice__Other__

In Case Of Emergency

Name of local friend or relative (not living at same address) _____

Relationship to patient: _____ Home phone no :( )_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Faith Pediatrics. I understand that I am financially responsible for any balance. I also authorize Faith Pediatrics or insurance company to release any information required to process my claims.

Patient/Guardian signature: _____ Date: _____

SUBMIT FORM