

## Harlingen Pediatrics Associates - Patient Registration

Name of Pediatrician, Hospital, city where child was born: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ Last First Middle Suffix  
MM DD YY Gender: \_\_\_\_\_ Phone (H) (\_\_\_\_) \_\_\_\_-\_\_\_\_

**Address:** \_\_\_\_\_ Mailing Zip Code City State

**Father/Guardian Primary Insurance Card Holder**  Please Check

**Name:** \_\_\_\_\_

**DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ Prefix Last First Middle Suffix  
MM DD YY Marital Status: \_\_\_\_\_ SS#: \_\_\_\_\_

**Address:** \_\_\_\_\_ Mailing Zip Code City State

Home Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_-\_\_\_\_

Employer: \_\_\_\_\_ Insurance: \_\_\_\_\_

**Mother/Guardian Primary Insurance Card Holder**  Please Check

**Name:** \_\_\_\_\_

**DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ Prefix Last First Middle Suffix  
MM DD YY Marital Status: \_\_\_\_\_ SS#: \_\_\_\_\_

**Address:** \_\_\_\_\_ Mailing Zip Code City State

Home Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_-\_\_\_\_

Employer: \_\_\_\_\_ Insurance: \_\_\_\_\_

### Additional Children

- Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Middle MM DD YY
- Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Middle MM DD YY
- Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Middle MM DD YY
- Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Middle MM DD YY

In case of Emergency Notify: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_ Relationship \_\_\_\_\_

In case of my absence, I authorize \_\_\_\_\_ to care for my child/children.  
(Other than Parents) Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_ Relationship \_\_\_\_\_

**It is very important on each visit that you present your current insurance card.** Please review the list of insurance carriers that we accept. The list is posted in the front reception area of the office. Our office will make every attempt possible to file your visits correctly. Please let us know as soon as possible if your insurance has changed. A statement will be sent to you if there is a balance that was not covered by your carrier.

If you have no insurance coverage or if your insurance is not listed as one of the company's that we file for, all professional services rendered are charged to the patient. You are required to pay services rendered at the time of the visit. Unless other arrangements have been made. The guarantor will be given the necessary forms at the time of the office visit to expedite your reimbursement. We do not wait for payment from your insurance company if you fail to keep your agreement to pay, your account may possibly be forwarded to a collection agency.

In case of hospital treatment, I authorize payment of medical benefits to undersign physician or supplier for services. I understand and agree if my insurance does not cover or if I have no coverage, I will be responsible for the charges incurred. I certify this information is true and correct to the best of my knowledge.

X \_\_\_\_\_ /\_\_\_\_/\_\_\_\_  
 Parent/Legal Guardian Signature Date