PATIENT REGISTRATION

DATE

NAME	M F	DATE OF BIRTH	PLACE & HOSPITAL OF BIRTH
STREET ADDRESS		CITY STATE, ZIP	PHONE ( )
EMAIL ADDRESS			
SCHOOL		REFERRED BY	
FATHER'S NAME		OCCUPATION / EMPLOYER	DATE OF BIRTH
WORK PHONE ( )		CELL PHONE ( )	S.S. #
MOTHER'S NAME		OCCUPATION / EMPLOYER	DATE OF BIRTH
WORK PHONE ( )		CELL PHONE ( )	S.S. #
GUARDIAN (other, self)		OCCUPATION / EMPLOYER	DATE OF BIRTH
WORK PHONE ( )		CELL PHONE ( )	S.S. #
EMERGENCY CONTACT (other than parents)		ADDRESS	PHONE ( )
CLOSEST RELATIVES (not at your address)		ADDRESS	PHONE ( )

INSURANCE & BILLING INFORMATION

PERSON RESPONSIBLE: ☐ FATHER ☐ MOTHER ☐ OTHER (RELATIONSHIP)

NAME OF INSURANCE	EFFECTIVE DATE

IF YOU DO NOT PAY COPAYMENT AND DEDUCTIBLE AT THE TIME OF OFFICE VISIT, THERE WILL BE AN ADDITIONAL $20.00 BILLING CHARGE

Assignment of Benefits to Physician

I hereby give authority for the payment of insurance benefits to be made directly of K.K. Bhatia, M.D. for services rendered. **I understand I am financially responsible for all charges whether or not they are covered by my insurance. This includes fees such as: deductibles, co-pay, missed appointments, record releases and school/sports forms.**

I hereby authorize K.K. Bhatia, M.D. to release all information necessary to secure payment of benefits. I further agree a photocopy of this agreement shall be as valid as the original. This assignment will remain in effect until resolved by me in writing.

I also acknowledge that I have received a copy of K.K. Bhatia, M.D.'s Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

I give Dr. K.K. Bhatia permission to medically treat my child.

Patient (please print): _____ Date: _____

Parent/Guardian (please print): _____ Signature: _____

K.K. Bhatia, M.D., F.A.A.P.

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