

**HOWARD COUNTY PEDIATRICS, LLC  
PATIENT REGISTRATION**

<input type="checkbox"/> NEW PATIENT	<input type="checkbox"/> NEW ADDRESS	<input type="checkbox"/> NEW PHONE	<input type="checkbox"/> NEW INSURANCE
	<input type="checkbox"/> Entire Family	<input type="checkbox"/> Home (Mom/Dad/Both)	<input type="checkbox"/> New Employer
	<input type="checkbox"/> Mom	<input type="checkbox"/> Work (Mom/Dad)	
	<input type="checkbox"/> Dad	<input type="checkbox"/> Cell (Mom/Dad)	

<p><b>POLICY HOLDER</b></p> <p>Relationship to Patient: _____</p> <p>Last Name: _____</p> <p>First Name: _____ M.I. _____</p> <p>Date of Birth: _____</p> <p>Address: _____</p> <p>City: _____ State: _____</p> <p>Zip: _____</p> <p>Social Security #: _____</p> <p>Employer: _____</p> <p>Occupation: _____</p> <p>Work Phone: _____</p> <p>Cell Phone: _____</p> <p>Home Phone: _____</p>	<p><b>OTHER PARENT</b></p> <p>Relationship to Patient: _____</p> <p>Last Name: _____</p> <p>First Name: _____ M.I. _____</p> <p>Date of Birth: _____</p> <p><input type="checkbox"/> Address same as <b>POLICY HOLDER</b></p> <p>Address: _____</p> <p>City: _____ State: _____</p> <p>Zip: _____</p> <p>Social Security #: _____</p> <p>Employer: _____</p> <p>Occupation: _____</p> <p>Work Phone: _____</p> <p>Cell Phone: _____</p> <p>Home Phone: _____</p>
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<b>Primary Number for Contact and Reminder Calls:</b> _____	
<b>Email address: (One per household)</b> _____	_____

<b>CHILDREN:</b>			
Last Name: _____	First Name: _____	M.I. _____	DOB: _____ Sex: M / F
Last Name: _____	First Name: _____	M.I. _____	DOB: _____ Sex: M / F
Last Name: _____	First Name: _____	M.I. _____	DOB: _____ Sex: M / F
Last Name: _____	First Name: _____	M.I. _____	DOB: _____ Sex: M / F

<b>OFFICE USE ONLY:</b>	
Primary Insurance: _____	Are your children covered by any other health insurance plans? Y / N
If yes: Secondary Insurance: _____	Policy Holder: _____
Have you provided complete information for the Policy Holder of Secondary Insurance? Y / N	
Date of current card on file: _____	

**AUTHORIZATION TO TREAT/INSURANCE AUTHORIZATION AND ASSIGNMENT**

I hereby authorize HOWARD COUNTY PEDIATRICS, LLC to provide medical treatment for my child/children. I hereby authorize the attending physician to release protected health information to my insurance carrier/s of record concerning my dependent/s. I hereby assign to the attending physicians all payments for medical services rendered to my dependent/s until revoked in writing. I understand that I am responsible for any amount not covered by insurance. I also understand that I am responsible for collection and legal costs should it be necessary for this account to be referred to a collection agency.

SIGNATURE OF PARENT OR GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_