JOSHI PEDIATRICS
PATIENT REGISTRATION

PHARMACY OF CHOICE: _____

PATIENT INFORMATION (To be completed by Patient's Guardian)

Name: _____
Last Name First Name M.I.

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Sex: [ ] M [ ] F Age: _____ Birth date: _____

RESPONSIBLE PARENT OR GUARDIAN INFORMATION

***RESPONSIBLE PARTY FOR BILL ☐ MOM ☐ DAD ☐ OTHER**

Mother's Name _____
Last Name First Name M.I.

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell Phone(s): _____

Employer: _____ Phone: _____

Father's Name _____
Last Name First Name M.I.

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell Phone(s): _____

Employer: _____ Phone: _____

PRIMARY INSURANCE

Insurance Name: _____ Group #: _____ SS/ID #_____

Subscriber's Name: _____ Birth Date _____

Subscriber's Address: _____ Phone: _____

Employer Name: _____ Phone: _____

ADDITIONAL INSURANCE

Insurance Name: _____ Group #: _____ SS/ID #_____

Subscriber'sName: _____ Birth Date _____

Subscriber's Address: _____ Phone: _____

Employer Name: _____ Phone: _____

SEE REVERSE SIDE OF FORM

Emergency Contact: _____Relation: _____ Phone: _____
(please list someone other than parents)

PATIENT REGISTATION

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned herby authorizes the release of any information relating to all claims for my benefits submitted on behalf of the above named patient. I further expressly agree and acknowledge that my signature on this document authorized my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and dependents, and that I will be bound by this signature as though the undersign had personally signed the particular claim.

I, _____ hereby authorize _____
(Parent's Name) (Name of Insurance Company)
To pay and hereby assign directly to _____ all benefits.
(Physician's Name)
I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits,

when received by and paid to _____ will be credited to my account,
(Physician's Name)
in accordance with the above assignment.

Signature of Guarantor: _____ Date: _____