Stockdale Podiatry Group

CHILD REGISTRATION FORM

PATIENT'S NAME_____

MAILING ADDRESS_____ ZIP_____ PHONE ( )_____-_____

SEX____ DATE OF BIRTH ___/___/___ SOCIAL SECURITY # _____-_____-_____

SHOE SIZE_____ REFERRED BY _____

RESPONSIBLE PARTY_____ RELATION_____

MAILING ADDRESS_____ ZIP_____ PHONE ( )_____-_____

FATHER'S NAME_____ DATE OF BIRTH ___/___/_____

MAILING ADDRESS_____ ZIP_____ PHONE ( )_____-_____

OCCUPATION_____ EMPLOYER_____

BUSINESS ADDRESS_____ ZIP_____ PHONE ( )_____-_____

SOCIAL SECURITY # _____-_____-_____ DRIVERS LICENSE #_____

MOTHER'S NAME_____ DATE OF BIRTH ___/___/_____

MAILING ADDRESS_____ ZIP_____ PHONE ( )_____-_____

OCCUPATON_____ EMPLOYER_____

BUSINESS ADDRESS_____ ZIP_____ PHONE ( )_____-_____

SOCIAL SECURITY # _____-_____-_____ DRIVER LICENSE #_____

IN CASE OF EMERGENCY, CONTACT _____ RELATION_____

ADDRESS_____ZIP_____ PHONE ( )_____-_____

PLEASE PRESENT RECEPTIONIST WITH INSURANCE CARDS AND/OR CLAIM FORMS.

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED TO STOCKDALE PODIATRY GROUP, INC.

THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS AGREEMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

PARENT/GUARDIAN'S SIGNATURE_____ DATE_____