Promise Pediatrics
375 Boynton Drive
Ringgold, GA 30736

PATIENT REGISTRATION FORM

Date: _____ Acct #:_____

RESPONSIBLE PARTY (PARENT OR LEGAL GUARDIAN)			
Billing Name:			SS#:
Street Address:			
City:	State:	Zip:	Phone#:
Relationship to Patient:			DOB:
Employer Name:			
Street Address:			
City:	State:	Zip:	Phone#:
PATIENT INFORMATION			
Patient Name:			Acct #
Street Address:			
City:	State:	Zip:	Phone#:
DOB:	SS#:		Sex:
EMERGENCY INFORMATION (Outside Home)			
Emergency Contact Name:			
Street Addresss:			
City:	State:	Zip:	Phone#:
Employer:			
Street Address:			
City:	State:	Zip:	Phone#:
Relationship to Patient:			
PREFERRED PHARMACY			
Name of Pharmacy:			
Address/Location:			Phone #:

I authorize payment of medical benefits to the provider of services rendered and authorize the release of any medical information necessary to process insurance claims and certify that the information contained in the form is correct. I have reviewed the HIPPA policy in place at Promise Pediatrics and am in agreement with it. I understand it is my responsibility to notify Promise Pediatrics of any changes in insurance coverage and if I fail to notify this office *I will be responsible for paying the bill in full*. I also understand that if the account is turned over to a collection agency, I am responsible for any fees related to this service.

_____ _____

Signature of Patient/Responsible Person Date