Today's Date:_____/_____/_____
PT Name _____

FAMILY REGISTRATION

PARENT #1_____DOB_____SS# _____❑Male❑ Female
Address_____Home Phone _____
City/State/Zip_____Cell Phone _____
Employer/Occupation_____Work Phone _____
Employer Address_____EMAIL _____

PARENT #2_____DOB_____SS# _____❑Male❑ Female
Address_____Home Phone _____
City/State/Zip_____Cell Phone _____
Employer/Occupation_____Work Phone _____
Employer Address_____EMAIL _____

PLEASE LIST PHONE NUMBER FOR APPOINTMENT REMINDERS - HOME ___ CELL ___ PARENT TO NOTIFY - ❑#1 ❑#2

Parents are: ❑Married ❑Living Together ❑Separated ❑Divorced If divorced, **who is the Custodial Parent: ❑#1 ❑#2**

Children: (child being seen today in #1 slot and all other siblings in family listed below)

1)Child Name _____DOB_____❑M ❑F SS# _____(Must have for ins verif/referrals)
2)Child Name _____DOB_____❑M ❑F SS# _____(Must have for ins verif/referrals)
3)Child Name _____DOB_____❑M ❑F SS# _____(Must have for ins verif/referrals)
4)Child Name _____DOB_____❑M ❑F SS# _____(Must have for ins verif/referrals)
5)Child Name _____DOB_____❑M ❑F SS# _____(Must have for ins verif/referrals)
6)Child Name _____DOB_____❑M ❑F SS# _____(Must have for ins verif/referrals)

Emergency Contact Person_____ Relation to child(ren)_____Cell# _____

Names of individuals, and relationship, (other than parents) of persons whom I give permission to bring in my child(ren) and be responsible for carrying out the directives given to them by Pediatric Associates. Please note that the person bringing in the child is responsible for payment.

Name_____Relationship to Pt_____Cell#_____
Name_____Relationship to Pt_____Cell#_____
Name_____Relationship to Pt_____Cell#_____

Who may we thank for referring you to us? _____

Please indicate name of PRIMARY CARE PHYSICIAN:

Mary E Keown **William R Davidson, MD** **Mary K Bartek, MD** **David A Wyckoff, MD** **Lori L Amis, MD**

****WE REQUIRE THAT YOU PRESENT YOUR INSURANCE CARD AT EVERY VISIT****

Your preferred Pharmacy_____**Location** _____

Authorization of Treatment and Assignment of Benefits: I authorize Pediatric Associates, to treat my child(ren). I further authorize the release of medical information necessary for the completion of insurance forms, school & camp forms. I authorize payment directly to Pediatric Associates, for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse Pediatric Associates for any payments my insurance company may have sent to me in error. **I understand that I am financially responsible for all co-payments and any charges not covered under my insurance benefits at the time of service.** I also understand that I am responsible for advising Pediatric Associates of any changes to my insurance. Failure to pay co-pay at that time will result in an additional billing charge. Our office requires 24-hours notice of appointment cancellations. Failure to provide this notice will incur a cancellation fee.

Signature_____Relationship_____Date _____

A photocopy or scan of this authorization shall be considered as effective and valid as the original.

2201 Murphy Avenue, Suite 201 • Nashville, TN 37203 • Phone 615-329-3595 • Business Fax 615-891-4442 • Secured fax 615-327-4934