Patient Registration Form

Thank you for choosing Kaleidoscope Kids as your healthcare provider. ***Please fill out the form completely.***

Patient Information

Child's Name: _____
Last MI First

Address: _____ City: _____ State: _____ Zip: _____

SS#:_____-_____-_____ DOB: ____/_____/_____ Sex: M F

How did you find out about Kaleidoscope Kids? _____

Insurance & Guarantor Information

Relationship to Patient: _____

Name: _____
Last MI First

Address: _____ City: _____ State: _____ Zip: _____

SS#:_____-_____-_____ DOB: ____/_____/_____ Sex: M F

Phone#: _____ Work#: _____ Mobile#: _____

Email: _____

Primary Insurance Company: _____ Phone#: _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

Subscribers ID#: _____ Group#: _____

Secondary Insurance Co.: _____ Telephone#: _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

Subscribers ID#: _____ Group#: _____

(PLEASE PROVIDE INSURANCE CARD WITH THIS INFORMATION)

Parent / Guardian Information

Parent Guardian #1: (If different than Guarantor)

Relationship to Patient: _____

Name: _____

SS#:_____-_____-_____ DOB: ____/_____/_____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Employment Status: _____ Employer: _____

Phone#: _____ Work#: _____ Mobile#: _____

Email: _____

Parent Guardian #2: (If different than Guarantor)

Relationship to Patient: _____

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

SS#:_____-_____-_____ DOB: ____/_____/_____ Sex: M F

Employment Status: _____ Employer: _____

Phone#: _____ Work#: _____ Mobile#: _____

Email: _____

Emergency Contact

Name: (someone who does not live with you):_____

Address: _____ City: _____ State: _____ Zip: _____

Phone#: _____ Work#: _____ Mobile#: _____

Relationship to patient: _____ Email: _____

Assignment of Benefits/Consent to Treat/Release of Information

I hereby authorize Kaleidoscope Kids/Meredith A. Byington, MD, P.A. the authority to treat and examine me/my dependent, and order any tests, diagnostic studies, treatment and other clinical services necessary for my own or my child's care and treatment.

I hereby authorize payment directly to Kaleidoscope Kids/Meredith A. Byington MD, P.A. of all insurance benefits payable for the services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of Patient/ Guardian Date