REGISTRATION INFORMATION

(PLEASE PRINT)

Date: ____ /____ /____

Please list all children in the family.

Name: _____ Birthday: ____ /____ /____ Name: _____ Birthday: ____ /____ /____

Name: _____ Birthday: ____ /____ /____ Name: _____ Birthday: ____ /____ /____

Name: _____ Birthday: ____ /____ /____ Name: _____ Birthday: ____ /____ /____

Home Address: _____
street city state zip

Mailing Address: _____
street city state zip

Telephone: Home: (_____) _____ - _____

Person financially responsible: _____ Whom may we thank for referring you?_____

Are parents of the child/chidren: ❑ Married ❑ Divorced ❑ Living Together ❑ Separated

IF PARENTS ARE DIVORCED OR SEPARATED, WHAT ARE THE LEGAL CUSTODY ARRANGEMENTS FOR THE CHILD/CHILDREN?

❑ JOINT LEGAL ❑ SOLE CUSTODY If sole custody, which parent has sole custody: _____

Biological Father's Name: _____

Address (if different from patient's):_____

_____

Work Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Employer: _____

Address: _____ City:_____

Social Security #: _____ - _____ - _____ Birthday _____ / _____ / _____

Driver's License #: _____

Other ID: _____

Biological Mother's Name: _____

Address (if different from patient's): _____

_____

Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Employer: _____

Address: _____ City:_____

Social Security #: _____ - _____ - _____ Birthday _____ / _____ / _____

Driver's License #: _____

Other ID: _____

Step-Parent's/Guardian's Name: _____ Address: _____

Social Security #: _____ - _____ - _____ Birthday _____ / _____ / _____

Driver's License or other ID#: _____ Employer: _____

Phone Numbers: _____ Is step-parent allowed to bring child/children to our office? ❑ Yes ❑ No

ASSIGNMENT AND RELEASE

I, the undersigned, have the above listed insurance and assign directly to Dr. Caliendo all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Date: _____ Signed: _____
PLEASE DO NOT SIGN UNTIL IN OFFICE

In the event of an Emergency, whom should we contact?

Name:_____ Relationship: _____ Phone: (_____) _____ - _____

Name:_____ Relationship: _____ Phone: (_____) _____ - _____