REGISTRATION FORM

Mother's Name: _____
Address: _____
_____
Home Phone: _____
Work Phone: _____
Mobile Phone: _____
Email: _____
Education Level: _____
Employer: _____
Occupation: _____
Date of Birth: _____

Father's Name: _____
Address: _____
_____
Home Phone: _____
Work Phone: _____
Mobile Phone: _____
Email: _____
Education Level: _____
Employer: _____
Occupation: _____
Date of Birth: _____

Primary Health Insurance: _____
Secondary Insurance: _____
Policy # Primary Insurance: _____
Subscriber Name: _____
Subscriber Insurance #: _____
Policy # Secondary Insurance: _____

Names & Birthdates of Children:

_____
_____
_____
_____
_____

Vaccine for Children Program Eligibility Screening:

Is the Child Native American (American Indian) or Alaskan Native? _____

I authorize payment of medical benefits to the Physician or supplier of Cedar Hill Pediatrics, LLC for the services rendered during my child(ren)'s examination or treatment, I also authorize my child(ren)'s Physician to release any information required in the course of their examination and/or treatment to my insurance company to determine these benefits or the benefits payable for related services.

SIGNED: _____ DATE: _____
(Parent/Guardian)