INFANTS CHILDREN & YOUTH
PATIENT REGISTRATION

Patient Name: (First) _____(Last)_____(Sex)_____

Birth Date: ____/____/____Street Address: _____

City/State: _____Zip: _____Phone: _____

Parent's/Guardian: _____ Cell: _____

Emergency Contact Person: _____Phone: _____

Allergies (Please Specify): _____

GUARANTOR INFORMATION:(person to whom you would like all billing correspondence forwarded)

Name _____Phone _____

Address (if different than the above) _____

City/State_____ Zip_____ Relationship to patient _____

Employer Information _____ Phone _____

Employer Address: _____ Occupation: _____

INSURANCE INFORMATION

1. Insurance Name _____ Phone _____

Address: _____City/State/Zip _____

Policy Holders Name _____ Birth Date _____

Social Security # _____Co Pay Amount _____Relation to patient _____

Policy/ID #_____ Plan/Group #_____

2. Insurance Name _____ Phone _____

Address: _____City/State/Zip _____

Policy Holders Name _____ Birth Date _____

Social Security # _____Co Pay Amount _____Relation to patient _____

Policy/ID #_____ Plan/Group #_____

RELEASE&ASSIGNMENT: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Blue Shield, HMO plans, and Commercial insurance to Infants, Children & Youth LTD. I understand that I am financially responsible for all charges whether or not covered by said insurance. I hereby authorize said assignee to release any information necessary to secure payment on my behalf.

Signature: _____Date: _____