BLUE FISH

PEDIATRICS

www.bluefishmd.com

Patient Registration

Child's Name: _____ **Date of Birth:** _____

First/Middle/Last mm/dd/yyyy

Gender: ☐ Male ☐ Female

Street Address: _____

City, State Zip Code: _____ Patient Phone Number (if over 13 years old): _____

Who referred you to our office?

Demographic Information

Race: American Indian | Asian | Black or African American | Hispanic or Latino | White | Other: _____ | Decline to Answer

Preferred Language: English | Spanish | Korean | Japanese | Other: _____ | Decline to Answer

Parent(s) / Guardian Information

Father's Name:		**Mother's Name:**	
Date of Birth:		Date of Birth:	
Social Security #:		Social Security #:	
Employer Name:		Employer Name:	
Employer Address:		Employer Address:	
Occupation:		Occupation:	
Home Phone:		Home Phone:	
Cellular Phone:		Cellular Phone:	
Work Phone:		Work Phone:	
Email Address:		Email Address:	

Siblings: Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Do they attend this office? Yes No If no, do you plan to bring them to this office? Yes No

Emergency Contact Name: _____ Phone: _____

Assignment of Insurance Benefits

I hereby authorize direct payment of medical benefits to Blue Fish Pediatrics, LLP for services rendered by its physicians in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance. Any services rendered outside of the clinic, i.e. lab work, blood tests, x-rays etc., that are not covered by insurance will be my financial responsibility.

Authorization to Release Information

I hereby authorize the physicians of Blue Fish Pediatrics, LLP to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

Medicaid

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

Patient Name (Please Print) _____ Date _____

Parent/Guardian Name (Please Print) _____ Signature _____