

ADVANCED PEDIATRICS

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Registration Form

Welcome to our practice. We look forward to helping you. To get started, we would appreciate you filling out this registration form.

Please let us know how you were referred to us: _____

Preferred e-Mail Address: _____

Mother (or guardian)

Father (or guardian)

Name:

Date of Birth:

Address:

Home Phone: ()

()

Employer:
Address:

Work Phone: ()
Social Sec. #:

()

Primary Insurance

Secondary Ins.

Subscriber Name

Insur. Co. Name

Address

Member #

Group # / Copay \$

Phone Number () ()

Please Complete Child(ren)'s Name(s) on Back of this Page

I hereby grant permission to Dr. Lavin and his staff and associates, to provide medical care for my child(ren), and to furnish the above insurance company(ies) all information which may be requested. I hereby assign to *Advanced Pediatrics* all monies to which I am entitled for medical expenses relative to the service(s) rendered by them. I understand that I am fully responsible to the doctor for charges not covered by this assignment or for services not covered by my insurance(s).

Parent/Guardian Signature

Date

Please List Your Child(ren)'s Information Below

Name

Date of Birth

SSN (if available)

1.

2.

3.

4.

5.

6.

7.

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12.