HYDE PARK PEDIATRICS

3330 Erie Ave, Suite 11 Cincinnati, OH 45208
7661 Montgomery Rd. Cincinnati, OH 45236

PATIENT REGISTRATION FORM

Patient's Name: ____
(Last) (First) (Middle)

Nickname: _________________________

Demographics:

Date of Birth: _____________________ Insurance Guarantor Name: _________________________

Sex (Circle one): Male Female Relationship to Child: ______________________________

Mother's Name: _________________________________ Date of Birth: _____________________

Occupation: ________________________ Employer: __________________________________

Home Address: ____

Phone: Home _____________________ Cell ______________________ Work _________________

Father's Name: ___________________________________ Date of Birth: _____________________

Occupation: ________________________ Employer: __________________________________

Home Address: ____

Phone: Home _____________________ Cell ______________________ Work _________________

Parents: (Circle One) Single Married Never Married Divorced Separated Partner Widow

Important!
New Patient: Call your insurance company to inform them and request a new card with your new PCP's name.

New Baby: Call your employer and insurance as soon as possible to add baby to your policy.

New Insurance: Bring your new card to us and update your record to file insurance claims.

I hereby authorize my insurance benefits to be paid directly to Hyde Park Pediatrics, Inc. realizing that I am responsible to pay non-covered services and procedures. I hereby authorize the release of pertinent medical information to insurance carrier(s). All professional services are to be paid when rendered and all balances due after insurance claim payment will be paid in full within ten days of statement unless other arrangements have been made in advance. *Please arrive a few minutes prior to your scheduled apt time to verify all your information.*

X ____ Date __________________________
(Parent/Legal Guardian Signature) In the event that the parents or legal guardian(s) are unable to accompany the child during an office visit, I hereby authorize Hyde Park Pediatric, Inc. to evaluate and treat any and all conditions that require attention.

X ____ Date ___________________________
(Witness Signature)