

Patient Registration
CONFIDENTIAL

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Welcome to our Office

Formedic

Patient Name	<input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Date
Street Address	City, State, Zip		
Phone # - Home ()	School		

Referred By

Mothers' Name	Date of Birth	S.S. #
Occupation Employer	Work Phone # ()	

Father's Name	Date of Birth	S.S. #
Occupation Employer	Work Phone # ()	

Guardian's Name (<input type="checkbox"/> self)	Date of Birth	S.S. #
Occupation Employer	Work Phone # ()	

Closest Relatives (Not at your address)	Address / Phone #
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Emergency Contact - Name (Other than parents)	Relation
Address	Phone # - Home ()

Billing Information & Responsible Party - *Payment Required at Time of Service - Unless Prior Arrangements Have Been Made*

Billing Name	Relation to Patient
Billing Address	

Insurance Information

Primary insurance Company	Phone # ()	Effective Date
Address		Group #
Name of Insured	Relation to Patient	ID#
		Benefit Code

Additional Insurance Company	Phone # ()	Effective Date
Address		Group #
Name of Insured	Relation to Patient	ID#
		Benefit Code

Medicaid #

DELSYM[®]
(dextromethorphan polistirex)
Extended-Release Suspension
COUGH FORMULA

**THE ONLY 12-HOUR OTC
LIQUID COUGH SUPPRESSANT**

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to Dr. _____, for services rendered by him / her in person or under his / her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. _____, 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.

A photocopy of these assignments shall be valid as the original.

Patient (please print) _____ Date _____

Parent / Guardian (please print) _____ Signature _____

ADDITIONS / CHANGES

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