KENWOOD PEDIATRICS

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*Patient Name:*_____
*Date of Birth:*_____, *Sex: M F*

*Responsible Party:*_____
*Date of Birth of Resp. Party:*_____
*Address:*_____
*Home Phone:*_____, *Work Phone:*_____
*Cell Phone:*_____

Referred By:_____

Primary Insurance*:*_____
*Subscriber Name:*_____
*Patients Relation to Subscriber:*_____
*Subscriber DOB:*_____
*ID No.*_____, *Group No.*_____
*Subscriber Address:*_____
*Subscriber Phone:*_____

Secondary Ins*.:*_____
*Subscriber Name:*_____
*Patients Relation to Subscriber:*_____
*Subscriber DOB:*_____
*ID No.*_____, *Group No.*_____
*Subscriber Address:*_____
*Subscriber Phone:*_____

Patient/Parent Authorization: I hereby authorize the physician to furnish information to insurance carriers concerning my illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as valid as the original.

_____ _____
Signature of Subscriber or Beneficiary *Date*

02/18/2010
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Patientregistration.doc