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BLUE RIDGE PEDIATRICS
Professional, Personalized Care for Newborns, Children & Adolescents

NORTH PARK OFFICE PARK
457-B HWY 123 BYPASS
SENECA, SC 29678

PATIENT REGISTRATION FORM

Referred By: _____ Please circle: Male Female

Patient Name: _____ Date of Birth: _____
(FIRST) (MIDDLE) (LAST)

Address: _____ City: _____ State/Zip: _____

PARENT OR GUARDIAN INFORMATION

Mother's Name: _____ Date of Birth: _____ S.S.N.: _____

Phone #: _____ Cell #: _____ Email: _____

Employer/Occupation: _____ Work Phone #: _____

Father's Name: _____ Date of Birth: _____ S.S.N.: _____

Phone #: _____ Cell #: _____ Email: _____

Employer/Occupation: _____ Work Phone #: _____

Emergency Contact: _____ Address: _____ Phone#: _____
(Other than Parent/Guardian)

Closest Relative: _____ Relationship: _____ Phone#: _____

GUARANTOR INFORMATION (PERSON FINANCIALLY RESPONSIBLE FOR BILL) AND BILLING INFORMATION

Person Responsible: Father Mother Other: _____ Relationship: _____

Billing Address: _____ Phone #: _____

Insurance Company: _____ ID#: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Blue Ridge Pediatrics, LLC, for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

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

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

Patient Name: _____ Date: _____

Parent/Guardian Signature: _____