REGISTRATION FORM

Mother's Name: ______________________

Address: ______________________

____

Home Phone: ______________________

Work Phone: ______________________

Alternate #: ______________________

Email: ______________________

Educational Level: ______________________

Employer: ______________________

Occupation: ______________________

Date of Birth: ______________________

Social Security No. ______________________

Father's Name: ______________________

Address: ______________________

____

Home Phone: ______________________

Work Phone: ______________________

Alternate #: ______________________

Email: ______________________

Educational Level: ______________________

Employer: ______________________

Occupation: ______________________

Date of Birth: ______________________

Social Security No. ______________________

Primary Health Insurance Plan: ______________________

____

Policy #: ______________________

Subscriber Name: ______________________

Subscriber Ins. #: ______________________

SS#: ______________________

Secondary Insurance: ______________________

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Name: ______________________

Address: ______________________

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Names & Birthdates of Children:

Name	Birth Date	Sex	Insurance # (if applicable)

Vaccine for Children Program Eligibility Screening:

Is the child Native American (American Indian) or Alaskan Native ____________

I authorize payment of medical benefits to the physician or supplier of PEDIATRIC ASSOCIATES OF NORWOOD & FRANKLIN, P.C. for services rendered during my child(ren)'s examination or treatment. I also authorize my child(ren)'s physician to release any information acquired in the course of their examination and/or treatment to my insurance company to determine these benefits or the benefits payable for related services.

SIGNED: ______________________ DATE: ______________________

(Parent/Guardian)