Frank R. Baum, M.D., Inc. Patient Registration

First Name_____ MI_____ **Last Name**_____

DOB_____ **Sex**: M or F Patient cell number (____) _____-_____

Physical Address _____ City_____ State_____ Zip_____

Mailing Address _____ City_____ State_____ Zip_____

Other children in household with DOB's: _____, _____,

_____, _____, _____,

Mother / Parent 1 /Primary Contact _____

First Name_____ **Last**_____

DOB_____ SSN# _____-_____-_____

Cell# (____) _____-_____ Home# (____) _____-_____

Work # (_____) _____-_____

Father / Parent 2 / Primary Contact _____

First Name_____ **Last**_____

DOB_____ SSN# _____-_____-_____

Cell# (_____) _____-_____ Home# (_____) _____-_____

Work # (____) _____-_____

Please identify the primary contact parent for appointment reminders and/or messages from our office.

Email: _____

Employer: _____

Occupation: _____

Email: _____

Employer: _____

Occupation: _____

Parents are: ( ) Married ( ) Living Together ( ) Separated ( ) Divorced

Child resides with: _____

If separated and/or divorced, who is the custodial Parent: ( ) Parent 1 ( ) Parent 2 ( ) both

INSURANCE INFORMATION

BILLING ADDRESS **If different than patient's address*

Responsible Party _____ Relationship_____ Contact # (____) _____-_____

Mailing Address _____City_____State_____Zip_____

Primary Insurance

Company Name: _____

Policy #:_____

Group #:_____

Subscriber: _____

Relationship: _____

Secondary Insurance

Company Name: _____

Policy #:_____

Group #:_____

Subscriber: _____

Relationship: _____

LIST ANY KNOWN ALLERGIES:_____

Account #_____

Race (please check all that apply)

( ) Native Hawaiian
( ) White
( ) Multiracial
( ) Asian
( ) Black/African American
( ) American Indian
( ) Refuse to report

Ethnicity (please check)

( ) Hispanic/ Latino
( ) **NOT** Hispanic/Latino

Primary Language (please check)

( ) English
( ) Other _____

Who locally to call in case of an Emergency **(Other than parents)**

1) _____PH# (____) _____-_____

2) _____PH# (____) _____-_____

AGREEMENT:
In consideration for services rendered to the above Patient by Frank R. Baum, M.D., Inc., the undersigned covenants and agrees as follows: All accounts will be paid within 45 days or arrangements made. In the event that a delinquent account is placed in the hands of a collection agency, or an attorney for collection, or suit is instituted on this account, I (we) agree to pay, in addition to the amount of the delinquent account and interest, a collector's or attorney's fee up to 50% of said delinquent account.

Parent/Guardian Signature_____Date_____

Account #_____