# MONROE PEDIATRIC ASSOCIATES

## A Division of Allied Physicians Group

**70 Gilbert Street ▪ Monroe, NY 10950**
**845-782-8616**

### PATIENT REGISTRATION FORM

***PATIENT (Name as it appears on Birth Certificate)***

First: _____ Middle: _____ Last: _____

Gender: Male Female DOB: _____ Mother's Maiden Name: _____

Any Custody Issues: Yes No If yes, please describe: _____

Address: _____ Apt.#_____ City: _____ State: _____ Zip: _____

**PARENT #1** ***(At Child's Address)*** **Please circle one: Biological Adoptive Legal Guardian Foster Step**

First:_____ M.I. _____ Last: _____ Gender: Male Female

DOB: _____ SSN: _____

Phone Numbers (w/ area code)

Home #: _____ Cell #:_____

**PARENT #2** ***(At Child's Address)*** **Please circle one: Biological Adoptive Legal Guardian Foster Step**

First:_____ M.I. _____ Last: _____ Gender: Male Female

DOB: _____ SSN: _____

Phone Numbers (w/ area code)

Home #: _____ Cell #:_____

**BIOLOGICAL / ADOPTIVE PARENT INFORMATION (*If not listed above*)** □ **Not Applicable**

***Mother*** - First:_____ M.I. _____ Last: _____

DOB: _____ SSN: _____

Address: _____ Apt.#_____ City: _____ State: _____ Zip: _____

Phone Numbers (w/ area code) - Home #: _____ Cell #:_____

***Father*** - First:_____ M.I. _____ Last: _____

DOB: _____ SSN: _____

Address: _____ Apt.#_____ City: _____ State: _____ Zip: _____

Phone Numbers (w/ area code) - Home #: _____ Cell #:_____

**CHILD'S INSURANCE INFORMATION**

***Primary Insurance*****:** _____ Child's ID #: _____ Group #: _____

Policy Holder: _____ DOB: _____ SSN: _____ Relationship: _____

Policy Holder's Address: _____ City: _____ State: _____ Zip: _____

***Secondary Insurance*****:** _____ Child's ID #: _____ Group #: _____

Policy Holder: _____ DOB: _____ SSN: _____ Relationship: _____

I authorize the release of any medical or other information necessary to process a claim. I understand and agree that I am responsible for the balance of my account for any professional services including any unmet deductibles, copayments and non-rendered services. I authorize payment of benefits directly to the physician if necessary. I further understand that in the event this account is turned over to an attorney for collection, I will be responsible for reasonable attorney's fees and all costs of collections.

Parent/Guardian Signature: _____ Date: _____