ABC Family Pediatricians
A practice of Lehigh Valley Physician Group

Home Office: ❑ Allentown ❑ Pond Road ❑ Laurys Station ❑ Center Valley ❑ Trexlertown ❑ Bethlehem Township

REGISTRATION FORM

Today's Date________________

Child's Full Legal Name ____ Gender M F

Birthdate______________________ SS # ______________________ Phone ________________

Address____

Race: B I M P R S U W N

Key: B – Black/African American I – American Indian/Alaskan Native/Eskimo M – Multi-racial
P – Pacific Islander R – Refused S – Asian U – Unavailable W – White N – Unknown: patient unsure of race

Parent #1 Name ____________________________ Social Security #______________ Birthdate __________

Address____

Home Phone # ________________ Work Phone # ________________ Cell Phone #________________

Employer ______________________________________ Occupation ________________________

Parent #2 Name ____________________________ Social Security #______________ Birthdate __________

Address____

Home Phone # ________________ Work Phone # ________________ Cell Phone #________________

Employer ______________________________________ Occupation ________________________

Email (optional) ____

RESPONSIBLE PARTY IF OTHER THAN PARENT LISTED ABOVE

Name ____________________________________ Birthdate _________ Relationship________________

Address____

Social Security # ______________________________ Home Phone # ________________________

Employer ______________________________________ Work Phone # ________________________

MEDICAL INSURANCE

Primary Insurance ____________________________

Subscriber____________________________

ID or Policy # ____________________________

Group # ______________ Plan # ______________

Secondary Insurance____________________________

Subscriber ____________________________

ID or Policy # ____________________________

Group # ______________ Plan #______________

Brothers/Sisters

Name ____________________________________ Birthdate __________ Race____________ Gender M F

Name ____________________________________ Birthdate __________ Race____________ Gender M F

Name ____________________________________ Birthdate __________ Race____________ Gender M F

All professional services rendered are charged to the parent. Payment is due at time of service unless it is covered by an insurance in which we participate.

I hereby authorize ABC Family Pediatricians to furnish information to insurance carriers concerning my child's illness and treatments.

I also authorize any insurance payment due to the physicians/providers to be paid directly to ABC Family Pediatricians.

Some services, including but not limited to well visits, sports pre-participation physicals, forms completion, after hours phone triage calls, and immunizations may not be covered by my insurance. I understand that I am responsible for any amount not covered by insurance.

Date:______________________ Parent's Signature:____