

Lockman & Lubell Pediatric Associates, LLC

Registration Form

Child 1: Last name: _____ First name: _____ MI: _____

DOB: ____ / ____ / ____ Sex: M / F Primary Dr: _____

Child 2: Last name: _____ First name: _____ MI: _____

DOB: ____ / ____ / ____ Sex: M / F Primary Dr: _____

Child 3: Last name: _____ First name: _____ MI: _____

DOB: ____ / ____ / ____ Sex: M / F Primary Dr: _____

Child 4: Last name: _____ First name: _____ MI: _____

DOB: ____ / ____ / ____ Sex: M / F Primary Dr: _____

Contacts

Please circle primary contact

Mother

Father

Name: _____

DOB: ____ / ____ / ____

Address: _____

Phone Numbers: *Please circle primary phone number*

Cell: _____

Home: _____

Email: _____

Employer: _____

Occupation: _____

Authority:

Exclusive

Joint

Emergency Only

Financial Only

Lives with patient? Yes No

Authority:

Exclusive

Joint

Emergency Only

Financial Only

Lives with patient? Yes No

Please provide us with any necessary paperwork supporting custody agreements.

Acknowledgement of Receipt Of The Notice Of Privacy Practice

I have received a paper copy of the Lockman & Lubell Pediatric Associates, LLC Notice of Privacy Practices.

Signature: _____ Date: _____



FINANCIAL RESPONSIBILITY/WAIVER FORM

Insurance authorization, verification and co-payments are the responsibility of the member.

I understand that if my insurance benefits and/or eligibility are not covered by my health insurance, then I am financially responsible and agree to pay for all charges related to the professional services of Lockman & Lubell Pediatrics LLC based on their financial policy.

Print patient's name

Patient/Guardian signature

Insurance carrier

Today's date