Today's Date:

Account #

PATIENT REGISTRATION

Parent's Information

Father's name_____ Mother's name_____

Date of Birth_____ Date of Birth_____

Address_____ Address_____

_____ Zip_____ Zip_____

Home phone_____ Cell_____ Home Phone_____ Cell_____

Social Security number_____ Social Security Number_____

Employer_____ Employer_____

Address_____ Address_____

_____ Zip_____ Zip_____

Phone_____ Phone_____

Email address_____ Email address_____

How did you hear of us?_____

Emergency Contact

Please provide name(s) and number(s) of nearest relative(s) living outside the home:

Name_____ Home phone_____ Cell/work_____

Name_____ Home phone_____ Cell/work_____

Patient Information

Pt. #	Name	Sex	DOB

Office Use Only

MCIR

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I understand that payment of all medical care is due at the time of service. The parent and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, **regardless of marital status**. I understand that I am responsible for any costs incurred in the collection of a patient's account incase of default, including reasonable attorney fees and court costs.

I hereby grant permission to Watch Me Grow Pediatrics to release any pertinent information to my insurance company upon request, and I also authorize payment directly to Watch Me Grow Pediatrics.

A photocopy of this authorization shall be considered as effective and valid as the original.

Parent Signature_____ Date_____