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

PATIENT INFORMATION
(Please use patient's Legal name)

First Name_____ MI_____ **Last Name**_____

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

Physical Address _____ City_____ State_____ Zip_____

Mailing Address _____ City_____ State_____ Zip_____

With whom does patient reside? _____Relationship_____

Other Children in Household: _____, _____,

_____, _____, _____,

Race (please check "x" all that apply)

( ) Native Hawaiian **( )** White

( ) Multiracial **( )** Asian

( ) Black/African American **( )** American Indian

( ) Refuse to report

Ethnicity (please check "x")

( ) Hispanic/ Latino

( ) **NOT** Hispanic/Latino

Primary Language (please check "x")

( ) English

( ) Other _____

PARENT INFORMATION

Mother/Parent 1

First Name_____ **Last**_____

DOB_____ SSN# _____-_____-_____

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

Work # (_____) _____-_____

PARENT INFORMATION

Father/Parent 2

First Name_____ **Last**_____

DOB_____ SSN# _____-_____-_____

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

Work # (____) _____-_____

Please circle the preferred contact number for appointment reminders and messages from the office.

Email: _____

Employer: _____

Occupation: _____

Email: _____

Employer: _____

Occupation: _____

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

If separated or divorced, who is the Custodial Parent: ( ) Parent 1 ( ) Parent 2 ( ) both

*****We cannot withhold information from a biological parent without a legal document stating parent has no rights. If a step-parent or other person is allowed to bring child in please give us the name and phone number of that person below. This will remain in effect until parent requests this to be changed. *****

Name _____Relationship_____PH# (____) _____-_____

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

1) _____PH# (____) _____-_____

2) _____PH# (____) _____-_____

Parent/Guardian Signature_____**Date**_____

INSURANCE INFORMATION

(You must provide the office with a copy of your current insurance card at every visit)

BILLING ADDRESS *If different than Patient's address

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

Mailing Address _____City_____State_____Zip_____

Primary Insurance

Company Name: _____ Policy #_____ Group #_____

Subscriber_____DOB_____Relationship_____

Employer_____Company Address_____

Secondary Insurance

Company Name: _____ Policy #_____ Group #_____

Subscriber_____DOB_____Relationship_____

Employer_____Company Address_____

IF YOU WANT US TO DISCUSS YOUR CHILD'S HEALTHCARE WITH SOMEONE OTHER THAN PARENTS/GUARDIAN PLEASE DOCUMENT HERE. IF SOMEONE CALLS AND THEY ARE NOT LISTED HERE WE CANNOT SPEAK TO THEM.

NAME: _____

RELATIONSHIP TO PATIENT: _____

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 #_____