WESTSIDE PEDIATRICS

PARENT OR CAREGIVER REGISTRATION FORM

PATIENT INFORMATION		
Last Name:	First Name:	DOB:
Name of child in practice:		
Address (if different):		Telephone #:

INSURANCE INFORMATION		
Do you have the same insurance as your child? YES NO		
If No, please fill out the following AND provide a copy of your insurance card.		
Person responsible for bill	Address (if different):	Telephone #:
Name of Primary Insurance:		

Subscriber's name:	Subscriber's SSN:	DOB:	Relationship:

FINANCIAL AGREEMENT

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Westside Pediatrics, P.C. or my insurance company to release any information required to process my claims.

Parent/Guardian signature Date

HEALTH QUESTIONS (CIRCLE YES OR NO)	
Fever or illness in the last 24 hours?	YES OR NO
Allergy to eggs or component of vaccine?	YES OR NO
Serious reaction to Flu Vaccine in the Past?	YES OR NO
Are you pregnant or possibly pregnant?	YES OR NO

Parent/Guardian signature Date

OFFICE USE ONLY: Circle one:	*L Deltoid*	*L Thigh*	*R Deltoid*	*R Thigh*
Provider Initials:				

Internal Use only:

Scanned

Initial and Date: