

**PATIENT REGISTRATION FORM**

Andrew M. Matthew M.D., Jessica M. Hochman M.D

**PERSONAL DATA**

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home #: \_\_\_\_\_ Email address: \_\_\_\_\_ May we contact you via email? Y / N

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**PARENT #1** Name: \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Drivers License Number: \_\_\_\_\_ State: \_\_\_\_\_

**PARENT #2** Name: \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Drivers License Number: \_\_\_\_\_ State: \_\_\_\_\_

**INSURANCE INFORMATION:**

Subscriber Name: \_\_\_\_\_ Insurance Company \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_ Phone# \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_ Phone# \_\_\_\_\_

**Financial Agreement:**

By signing below, I hereby certify the correctness of the above information and authorize the release of information to my insurance company. I assign benefits to Andrew M. Matthew, MD, and/or Jessica M. Hochman, MD. A photocopy of the assignment may serve as an original. I hereby agree that in consideration for services rendered by the doctor(s), I shall make prompt payment to my account as bills are presented. I also understand that I am ultimately responsible for my bill regardless of my insurance coverage.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Permission to Treat:**

I give permission to Andrew M. Matthew, M.D and Jessica Hochman, M.D. to render treatment for my minor children.

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_