

CHRISTAKIS PEDIATRICS

Patient Enrollment Form

Welcome to our practice! Please clearly PRINT out the information requested. Thank you.

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Sex: _____ - _____ SSN if avail: _____

Whom may we thank for referring you to our practice? _____

Mother's Name (guardian): _____ Date of Birth: _____

Address/City/State/Zip: _____

Home Phone: () _____ Work phone: () _____ Cell() _____

Occupation/Employer: _____ SSN _____

Father's Name (guardian) _____ Date of Birth: _____

Occupation/Employer: _____ SSN _____

_____ Check here if father has same address and phone numbers. If different, please continue.

Father's Address/City/State/Zip: _____

Home Phone: () _____ Work phone: () _____ Cell() _____

Name of Insurance/Policy Number: _____

Name of Primary Insured/Cardholder: _____

Information Release Authorization/Payment Responsibility

I hereby authorize:

- 1. Dr Paul Christakis to release any information concerning the patient to any health care professional or medical facility, necessary for coordination of care.**
- 2. Any health care professional or facility to release all information concerning the patient to Dr Paul Christakis, necessary for coordination of care.**
- 3. Dr Paul Christakis to release any information necessary for the processing of insurance claims for services provided.**
- 4. Dr Paul Christakis or any medical professional filling in for Dr Christakis to examine and treat the above-named child.**
- 5. That payment be made directly to this provider for professional services rendered.**

Also,

-- I shall be directly responsible for any unpaid balance, and I will be responsible for supplying Christakis Pediatrics PA with correct and updated insurance information. Insurance denials due to outdated information may be billed directly to me.

-- I accept responsibility for payment of copays, outstanding balances at the time of visit, and payment of an annual fee of \$250 per family. In addition, I agree that a copy of these signed agreements will be as valid as the original.

The information I have provided on this form is true and correct to the best of my knowledge.

I have read and agree with the above.

Signature: _____ Relation to Patient: _____