Pediatrics *for* You, PLLC
Shakti K. Matta, MD, MS, FAAP
Family Registration Form

PATIENT(S) INFORMATION (For Children under same insurance, if different please use separate forms)

First Name	Middle Name	Last Name
DOB	Age	Sex	SSN

First Name	Middle Name	Last Name
DOB	Age	Sex	SSN

First Name	Middle Name	Last Name
DOB	Age	Sex	SSN

First Name	Middle Name	Last Name
DOB	Age	Sex	SSN

First Name	Middle Name	Last Name
DOB	Age	Sex	SSN

CHILD(REN) LIVES WITH: MOM _____ DAD _____ BOTH _____ OTHER_____

Street Address Apt. # City State Zip Code

RESPONSIBLE PARTY INFORMATION (PERSON RESPONSIBLE FOR PAYING BILLS/GUARANTOR)

Guarantor Full Name	Relationship to Patient
DOB	SSN	Driver's License No.

Street Address Apt. # City State Zip Code

Home Phone	Cell Phone	Work Phone	Preferred E-mail

Occupation	Employer's Name

Employer's Address

Spouse/Significant Other Name	Relationship to Patient
DOB	SSN	Driver's License No.

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Street Address	Apt. #	City	State Zip Code
Home Phone	Cell Phone	Work Phone	Preferred E-mail
Occupation	Employer's Name		
Employer's Address			

HOW DID YOU HEAR ABOUT US? (Please circle one): Newspaper Friend Phone-book Web-site Physician (Name:) Other

PATIENT'S INSURANCE INFORMATION

Primary Insurance	Subscriber's Name	Relationship to Patient
Insurance ID/Policy #		Group #
Primary Subscriber Address (if different than Responsible Party)		Primary Subscriber DOB
Secondary Insurance	Subscriber's Name	Relationship to Patient
Insurance ID #		Group #
Secondary Subscriber Address		Secondary Subscriber DOB

EMERGENCY CONTACT

Name of Person Not Living With Patient			Relationship
Street Address	Apt. #	City	State Zip Code
Home Phone	Cell Phone	Work Phone	E-mail

ASSIGNMENT OF BENEFITS-FINANCIAL AGREEMENT

I hereby give lifetime authorization, unless revoked by me in writing, for payment of insurance benefits to be made directly to *Pediatrics for You, PLLC/Shakti K. Matta, MD* and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney fees. I hereby authorize *Shakti K. Matta, MD and his staff* to release all information necessary to secure payment of benefits.
I further agree that a photocopy of this agreement shall be as valid as the original. I acknowledge receipt of notice of privacy practices.

Date: Name: Signature: