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

PATIENT INFORMATION			
First Name	Middle Name		Last Name
DOB	Age	Sex	SSN
Street Address Apt. # City State Zip Code			

Please circle one or more races to indicate what you consider your child to be: White Asian Black/African American American Indian/Alaska Native Native Hawaiian/Pacific Islander
Is your ethnic group Spanish/Hispanic/Latino? Yes No
Preferred Language:_____

RESPONSIBLE PARTY INFORMATION (PERSON RESPONSIBLE FOR PAYING BILLS/GUARANTOR)			
Full Name (1)		Relationship to Patient	
DOB	SSN		Driver's License No.
Street Address Apt. # City State Zip Code			
Mailing Address (if different) 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.
Street Address Apt. # City State Zip Code			
Mailing Address (if different) City State Zip Code			
Home Phone	Cell Phone	Work Phone	Preferred E-mail
Occupation	Employer's Name		
Employer's Address			

Insurance Card (Front & Back)
NPP
Co-Payment
Mailing Address

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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: