FAMILY REGISTRATION FORM

Wishing Well
CHILDREN'S CLINIC

Today's Date: ____ /____ /____

CHILD'S NAME [First, Middle, Last]	**GENDER** M or F	**DATE OF BIRTH**	**RACE:**	**ETHNICITY**
		___ /___/____		Hispanic Non-Hispanic
		___ /___/____		Hispanic Non-Hispanic
		___ /___/____		Hispanic Non-Hispanic
		___ /___/____		Hispanic Non-Hispanic
		___ /___/____		Hispanic Non-Hispanic

HOW DID YOU FIND US?

☐ Insurance Plan ☐ Web Search ☐ Referred by: _____ ☐ Close to home ☐ Social Media ☐ Other: _____

	PARENT/GUARDIAN #1	**PARENT/GUARDIAN #2**
NAME		
RELATIONSHIP TO PATIENT(S)		
DATE OF BIRTH		
SOCIAL SECURITY #		
HOME ADDRESS		
CELL #		
HOME #		
WORK #		
EMAIL ADDRESS		
EMPLOYER		
OCCUPATION		

Parents are: ☐ Married ☐ Living Together ☐ Separated ☐ Divorced [if divorced, who is the Custodial Parent? ☐#1 ☐#2]

AUTHORIZATION FOR NON-PARENT TO CONSENT TO CARE

I authorize the following persons [18+ years old] to seek medical care in my absence for the listed child(ren) above. They may consent for treatment including vaccines, medications, labs and well and/or sick care.

NAME	PHONE #	RELATIONSHIP TO PATIENT	EMERGENCY CONTACT for the patient?
			YES / NO
			YES / NO
			YES / NO

INSURANCE INFORMATION

Is this patient covered by insurance? ☐ Yes ☐ No [self-pay]

Policy Holder:	Birth date:	Relation to patient:
Policy Holder's Address:		Policy Holder's Phone #:
Employer Name:	Employer Address:	Employer Phone #:
Insurance Name:	Policy/Subscriber ID #:	Group #:

PHARMACY NAME	**PHARMACY ADDRESS**	**PHARMACY PHONE #**

Authorization of Treatment and Assignment of Benefits: I authorize Wishing Well Children's Clinic, to treat my child/children. I further authorize the release of medical information necessary for the completion of insurance forms, school & camp forms. I authorize payment directly to Wishing Well Children's Clinic, for any and all medical or surgical benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse Wishing Well Children's Clinic for any payments my insurance company may have sent to me in error. I understand that I am financially responsible for all co-payments and any charges not covered under my insurance benefits. I also understand that I am responsible for advising Wishing Well Children's Clinic of any and all changes to my insurance. Payment of co-pays are due on date of service. Failure to pay co-pay at that time will result in an additional billing charge as outline in Financial Policy. Our office requires 24 hours notice of appointment cancellation. Failure to provide this notice will incur a cancellation fee. PLEASE SEE FINANCIAL POLICY.

Parent/Guardian Name: _____

Signature: _____ Date: _____