Troy Pediatrics, PLC

Phone # (248) 435-9310
Fax # (248) 435-9360

Patient Registration Form

Patient Information

Patient: _____ Sex: ☐ M ☐ F DOB(mm/dd/yy): _____ SS# _____
(first, middle, last)

Mother/Guardian: _____ DOB(mm/dd/yy) : _____ SS# _____
Address: _____ Home Phone: _____
City/State/Zip: _____ Cell Phone: _____
E-Mail: _____ Occupation: _____
Employer: _____ Work Phone: _____

Father/Guardian: _____ DOB(mm/dd/yy): _____ SS# _____
Address: _____ Home Phone: _____
City/State/Zip: _____ Cell Phone: _____
E-Mail: _____ Occupation: _____
Employer: _____ Work Phone: _____

Number of Siblings: _____
Children live with ☐ Mother ☐ Father ☐ Guardian:
Emergency Contact Person: _____ Relationship _____ Phone # _____
Party responsible for payment of medical services: ☐ Father ☐ Mother ☐ Guardian ☐ Both
How were you referred to the office? _____

Insurance Information

Primary _____ Claims Address _____
Policy # _____ Group # _____ Co-payments $ _____
Secondary _____ Claims Address _____
Policy # _____ Group # _____ Co-payments $ _____
Name of Insured: _____ Relationship: _____
Medicaid ID # _____
Physician Listed on Card: _____ Phone: _____

Authorization of Treatment and Assignment of Benefits

I authorize **Dr. Neda Saker** to treat my child. I further authorize the release of medical information necessary for the completion of insurance payments directly to **Dr. Neda Saker** for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. Medical care or immunization can not be given unless my child is accompanied by one of the following

I understand that if my child's physician or any person employed by or under the direction and control of my child's physician(s) is directly exposed to my child's body fluids in any manner which may according to the then current guidelines for the Center of Disease Control (CDC), transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Parent/Guardian Signature _____ Relationship _____ Date _____

Witness Signature _____ Date _____

☐ I prefer to do my own insurance filing. Signed _____ Date _____