PATIENT REGISTRATION DATE ______________________________

PATIENT'S LAST NAME | PATIENT'S FIRST NAME | MI | DOB | AGE | SEX

ADDRESS | CITY | STATE | ZIP

PATIENT'S TELEPHONE | REFERRED BY (INCLUDE NAME & ADDRESS

PEDIATRICIAN'S NAME | ADDRESS | TELEPHONE

BILL TO – PARENT OR GUARDIAN

FATHER OR GUARDIAN'S LAST NAME | FIRST NAME | MI

ADDRESS IF DIFFERENT | CITY | STATE | ZIP CODE

TELEPHONE | HOME | CELL | WORK

MOTHER OR GUARDIAN'S LAST NAME | FIRST NAME | MI

ADDRESS IF DIFFERENT | CITY | STATE | ZIP CODE

TELEPHONE | HOME | CELL | WORK

EMPLOYER INFORMATION

GUARANTOR NAME AND EMPLOYER	SPOUSE'S NAME & EMPLOYER
ADDRESS	ADDRESS
TELEPHONE / OCCUPATION	TELEPHONE / OCCUPATION

PRIMARY MEDICAL INSURANCE INFORMATION

NAME OF INSURANCE COMPANY

NAME OF INSURED	SOCIAL SECURITY NUMBER	DATE OF BIRTH
POLICY NUMBER	GROUP NUMBER	

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize Dr. Minou W. Colis to release any information acquired in the course of my examination or treatment to my family or insurance company. I authorize direct payment of medical benefits to Dr. Minou W. Colis for professional services rendered. I am aware that if there is inadequate insurance information on file for me the charges incurred will be my responsibility. I also understand that I am financially responsible for any outstanding balance.

SIGNED (PATIENT OR PARENT IF MINOR) DATE