

MMP Pediatric Surgery – Patient Registration

Please complete and bring to office appointment. Thank you.

Name: _____
 First M.I. Last

Mailing Address: _____
 Street City State Zip

Phone: _____ Birthdate: ____/____/____ Sex: M F
 Area Code mm dd yyyy

Referring Physician: _____ Pediatrician: _____

Mother's Name: _____	SS# _____
Work Number: _____	Cell Number: _____

Father's Name: _____	SS# _____
Work Number: _____	Cell Number: _____

PRIMARY INSURANCE INFORMATION:

 Name of Insurance Company I.D. No. Group No.

 Mailing Address for Claims (Street/PO Box, City, State, Zip) Phone No.

 Name of Policy Holder _____/_____/_____
 Birthdate Social Security No.

Address (if different than above): _____

 Policy Holder's Employer

SECONDARY INSURANCE INFORMATION:

 Name of Insurance Company I.D. No. Group No.

 Mailing Address for Claims (Street/PO Box, City, State, Zip) Phone No.

 Name of Policy Holder _____/_____/_____
 Birthdate Social Security No.

Address (if different than above): _____

 Policy Holder's Employer

Is condition/illness related to: Auto Accident ? Work Injury ? Date of Injury: _____

Authorization

I hereby authorize MMP ~ Pediatric Surgery to release any information contained in my child's medical record to my insurance company, referring physician/s, and/or primary care doctor.

I hereby authorize for benefits to be paid directly to MMP ~ Pediatric Surgery for medical and/or surgical services my child receives from any of the physicians in this practice. I understand that I will be responsible for any unpaid balance, including charges for which a referral was not obtained.

I understand that a copy of MMP ~ Pediatric Surgery's' Notice of Privacy Practices is available to me upon request and that if I have any questions about this notice, I may contact the Privacy Office in writing at 887 Congress Street, Suite 300, Portland, ME 04102 or by telephone (207) 662-5555.

Patient Name

Date of Birth

Parent/Guardian Signature

Date

Revised 05/29/07