Northeast Pediatrics, LLC
281 North 12th Street Suite E
Lehighton, PA 18235
610-377-6969

Today's Date_____

Pediatrics Patient Registration

Patients Name_____ M F Date of Birth_____
Address_____ APT #_____
City_____ State_____ Zip_____
Phone_____ School District_____
Parent Email Address_____

Fathers Name_____ Occupation_____
Date of Birth_____ SS #_____
Driver's License #_____

Mothers Name_____ Occupation_____
Date of birth_____ SS #_____
Driver's License #_____

Guardian's Name_____ Occupation_____
Date of Birth_____ SS #_____
Driver's License #_____

Emergency Contact _____ Address_____
Phone_____

Closest Relative _____ Address_____
Phone_____

INSURANCE/BILLING INFORMATION

Type of Insurance_____ ID#_____
Subscribers Name_____ Date of Birth_____
Group # _____

Payment/Copay requested at time of visit unless prior arrangements have been made.

Assignment of Insurance Benefits

I hereby authorize direct payment of surgiacl/medical benefits to Northeast Pediatrics, LLC, for services rendered by the office in person or under the doctors supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization to release information.

I hereby authorize Northeast Pediatrics, LLC to release any medical or incidental information that may be necessary for either medical care of in processing applications for financial benefits.

Patients Name_____

Parents/Guardians Printed Name_____

Partents/Guardians Signature_____