

**SUPERIOR / NELSON / EDGAR FAMILY MEDICAL CENTER  
PATIENT REGISTRATION FORM FOR CHILD**

PLEASE PRINT

DATE \_\_\_\_\_

Patient's name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ Male \_\_\_ Female \_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Parent's Marital Status \_\_\_ Married \_\_\_ Divorced \_\_\_ Single \_\_\_ Widowed

Mother's name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Mother's address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Phone # \_\_\_\_\_

Father's name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Father's address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Phone # \_\_\_\_\_

**PARENT'S OR GUARDIAN'S WORK INFORMATION**

Mother's work: \_\_\_\_\_ Occupation \_\_\_\_\_

Work address \_\_\_\_\_ Work phone # \_\_\_\_\_

Father's work: \_\_\_\_\_ Occupation \_\_\_\_\_

Work address \_\_\_\_\_ Work phone # \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance Company Name \_\_\_\_\_

Address \_\_\_\_\_

Policyholder \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Other Insurance \_\_\_\_\_

Address \_\_\_\_\_

Policyholder \_\_\_\_\_ Group # \_\_\_\_\_

**RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS**

By signing this form, you are granting consent to the providers of Superior/Nelson/Edgar Family Medical Center, P.C. and associated physicians for the purpose of treatment. I also authorize Superior/Nelson/Edgar Family Medical Center, P.C. and associated physicians to release to Medicare carriers or the insurance carriers listed above, any information needed for this or a related claim. I permit a copy of the this authorization to be used in place of the original and request payment of medical benefits either to myself or to the party who accepts assignment on all future claims. I understand that even though I have some type of insurance coverage, I am responsible for payment of services including any finance charges incurred on charges older than 90 days. This signature also acknowledges that you have received a copy of our Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Parent or Responsible Party