



Physicians of River Ridge

A Department of Children's Hospital

Registration Form

Account No. _____

Father's Information

Last Name		First Name		Middle Initial
Street Address				
City		State	Zip	
Home Phone		Social Security #	Date of Birth	
Employer			Work or cell phone ()	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____	
<input type="checkbox"/> White <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Multi-racial <input type="checkbox"/> Other _____				

Mother's Information

Last Name		First Name		Middle Initial
Street Address				
City		State	Zip	
Home Phone		Social Security #	Date of Birth	
Employer			Work or cell phone ()	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____	
<input type="checkbox"/> White <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Multi-racial <input type="checkbox"/> Other _____				

Children's Information:

(1) Last Name		First Name		Middle Initial
<input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth:	Social Security No:	
(2) Last Name		First Name		Middle Initial
<input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth:	Social Security No:	
(3) Last Name		First Name		Middle Initial
<input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth:	Social Security No:	
(4) Last Name		First Name		Middle Initial
<input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth:	Social Security No:	

Insurance Information

Insurance Company (1):		Policy No:
Phone No. to verify:		Name of Insured:
Insurance Company (2):		Policy No:
Phone No. to verify:		Name of Insured:
Medicaid (Please present Medicaid card)		
Is child insured by Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicaid no.

Emergency Contact

Name:	Relationship to Patient
Phone:	

Please read, sign and date

I authorize Physicians of River Ridge to bill my insurance company for charges incurred. I authorize Physicians of River Ridge to release medical information requested by the insurance company with regard to claims filed on behalf of children listed above. I understand that I will be responsible for charges denied or not covered by my insurance company. This would include co-payments not paid at time of service.

Signature 			Date / /		
----------------------	--	--	--------------------	--	--

Initials	Date	Initials	Date	Initials	Date
----------	------	----------	------	----------	------