Kids R Us
PEDIATRICS
Kids Are Our Specialty

New Patient Registration

Patient(s) Information: Please list ALL children who will be seen in this office. Use the back if additional space is needed.

Name: First Middle Last	Date of Birth (dd/mm/yyyy)	M/F	Social Security Number

Address: _____

City: _____ State: _____ Zip: _____

How would you like to be reminded of your child's appointment? ☐ Text ☐ Phone Calls ☐ E-Mail

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Parent/Guardian: _____

Birthdate: _____/_____/_____

SS#: _____-_____-_____

Address: ☐ Check if same as patient address

_____

Phone (H) _____

Phone (C) _____

Phone (W) _____

Email _____

Choose your relation to the patient:

◯ Mother/Father ◯ Step-parent ◯ Foster Parent ◯ Guardian

Parent/Guardian: _____

Birthdate: _____/_____/_____

SS#: _____-_____-_____

Address: ☐ Check if same as patient address

_____

Phone (H) _____

Phone (C) _____

Phone (W) _____

Email _____

Choose your relation to the patient:

◯ Mother/Father ◯ Step-parent ◯ Foster Parent ◯ Guardian

Emergency Contact	Relationship	Phone Number

121 Golfview Dr. NE, Arab, AL 35016
Phone: (256) 931-5437
Fax: (833) 753-1386

www.kidsruspediatrics.com
kidsruspediatrics@gmail.com

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Primary Insurance Information (if insurance is provided, please complete the information below)		
Insurance Name	**Policy ID #**	**Group #**
Claims Address	**Phone #**	**Patient Relationship to Subscriber:**
Subscriber's Name		**DOB:**
Subscriber Address (if different than guarantor)		**Subscriber Employer**
Secondary Insurance Information (if insurance is provided, please complete the information below)		
Insurance Name	**Policy ID #**	**Group #**
Claims Address	**Phone #**	**Patient Relationship to Subscriber:**
Subscriber's Name		**DOB:**
Subscriber Address (if different than guarantor)		**Subscriber Employer**

Consent For Treatment: I consent to necessary treatment, including drugs, medicine, performance of operation and to conduct x-ray, or other studies that may be used by the treating physician, nurse or staff. Initial: _____

Authorization For Release Of Information: I authorize Kids R Us Pediatrics to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on the job injury. Initial: _____

Assignment of Benefits: I hereby authorize release of information necessary to file a claim with my insurance company and assign payment of all medical benefits to Kids R Us Pediatrics. In addition, I authorize the release of my child/dependent's medical information by or between my treating physician and my insurer, HMO, health benefits payer, or any other entity (including but not limited to third party administrators, management companies, and provider networks) included in the administration of my child/dependent's health benefits. Initial: _____

Guarantee of Account: For services furnished by Kids R Us Pediatrics I hereby guarantee the payment of all accounts for services rendered**. For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all cost of collection, including attorney's fee and a collection fee of 50% of the balance due.** Initial: _____

Signature: _____ Date: _____

☐ By checking this box I consent to the use of my e-signature on this form.

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