Liberty Pediatrics & Family Medicine, LLC

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Date: ________________________

New Patient Registration-Child/ren

Patient's Name ____ Date of Birth __________________

Patient's Address____ M / F **Email ______________________

____ Phone No. ____________________

First and Last Names of siblings and their dates of birth:

____ DOB _________________ Allergies________________

____ DOB _________________ Allergies________________

____ DOB _________________ Allergies________________

____ DOB _________________ Allergies________________

Mother's Name _____________________________________ Date of Birth______________ Home Phone________________

Address (if different from patient) ____ Cell Phone________________

____ Work Phone_______________

Father's Name ______________________________________ Date of Birth______________ Home Phone________________

Address (if different from patient) ____ Cell Phone________________

____ Work Phone______________

EMERGENCY CONTACT IF PARENT(S) ARE NOT AVAILABLE

Name ____ Relation ______________________

Home Phone________________________________ Cell Phone ___________________________

Pharmacy preference __________________________ Phone number ____________

Primary Lab ________________________________

5963 Exchange Drive, Suite 100
Eldersburg, MD 21784

Telephone:
410-549-0900

Fax:
410-549-6121

<u>Patient Registration Page 2: Insurance Information</u>

Failure to provide complete and correct information may result in the patient being responsible for the FULL amount of the charge.

State insurances require you to choose a primary care physician (PCP). WE VALIDATE INSURANCE COVERAGE FOR EVERY VISIT. IF WE ARE NOT THE PCP ON RECORD, WE WILL NOT BE ABLE TO SEE YOUR CHILDREN UNTIL IT IS CHANGED. You will need to call the insurance to change the PCP and provide our office with a reference number. If you do not change the PCP and our office is <u>not paid</u>, we will not be able to see your family in the future.

Primary Insurance

Name of Insurance Company ____

Address for Claim Submissions ____

Insurance Company Phone Number ____

Policy Holder's Name ______________________________ Policy Holder's Birth Date ____________

Employer ______________________________ Membership ID# ____________________

Group # ______________________________ Effective Date ____________________

Copay ____________________

Secondary Insurance

Name of Insurance Company ____

Address for Claim Submissions ____

Insurance Company Phone Number ____

Policy Holder's Name ______________________________ Policy Holder's Birth Date ____________

Employer ______________________________ Membership ID# ____________________

Group # ______________________________ Effective Date ____________________

Copay ____________________

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