After Hours Clinic VI, P.A.
11886 Lake Underhill Rd.
Orlando, FL 32825

Phone # (407)447-7773
Fax # (407)447-7804

Registration Form

Account No.____________________________ Date__________________________________
Patients Name____________________________________ Birthdate______________________________
Address_____________________________________ City_________________ State_______ Zip________
Social Security #_____________________________ Sex M F Home Phone ( )___________________
Primary Physician__________________________ Physician Phone #______________________________
How did you hear about us?

☐ Friends/Family ☐ Insurance Company ☐ Magazine ☐ Internet ☐ Sign

☐ Other, (Please name)__________________________

Mother's Name_____________________________
SSN______________________ DOB___________
Address___________________________________
City____________ State________ Zip__________
Phone______________ Work Phone___________
Marital Status______________________________
Employer___________________________________
Occupation_________________________________

Father's Name_____________________________
SSN______________________ DOB___________
Address___________________________________
City____________ State________ Zip__________
Phone______________ Work Phone___________
Marital Status______________________________
Employer___________________________________
Occupation_________________________________

Emergency Contact__________________________ Phone ( )_____________________________
Address______________________________________ City_________________ State_______ Zip_______
Relationship to Patient____

INSURANCE INFORMATION

Primary Insurance

Policy Holder Name______________________
Insurance Company_______________________
Address_______________________________
____
Phone ( )_______________________________
Effective Date__________________________
ID/Contract#____________________________
Group/Plan#_____________________________

Secondary Insurance

Policy Holder Name______________________
Insurance Company_______________________
Address_______________________________
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Phone ( )_______________________________
Effective Date__________________________
ID/Contract#____________________________
Group/Plan#_____________________________

Assignment of Benefits:
I understand that I am responsible for the accuracy of the information I have provided on this form.
I authorize treatment of the above patient.
I authorize the release of medical records necessary to process insurance claims.
I am responsible to pay for all services received, regardless of insurance coverage.
I authorize payment of medical/surgical benefits to be made directly to Kidsville Pediatrics VI, P.A. After Hours Clinic.
I authorize the release of correspondence and/or medical records to other medical providers involved in my child’s care.
I have read and understand the Financial Policy.

Signature____Date______________________

Patient/Parent/Legal Guardian (Please Circle)