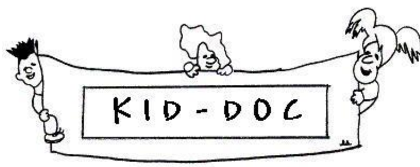


# PEDIATRICS

Dr. Shahzad A. Sheikh, M.D., F.A..A..P

# Patient Registration

**PATIENT(S) DEMOGRAPHIC(S)**

Patient Name________________________ SSN ______________ DOB ___________ Age________ Sex: M ☐ F ☐

Patient Name________________________ SSN______________ DOB ___________ Age________ Sex: M ☐ F ☐

Patient Name________________________ SSN______________ DOB ___________ Age________ Sex: M ☐ F ☐

**Contact Name:** ____________________________________________ **Text/Email:**___________________________

**Street Address:** ________________________________________________ **Phone:** __________________________

**City/State/Zip:** ________________________________________________ **Apt:** ___________________________

**How did you hear about us?**
**Insurance Directory ____ Google Ad ____ FB: ____ Instagram____ ZocDoc____ Word of Mouth _____**

**Referred By: OB-Gyn____________________________ Other_________________________________**

**MOTHER'S EMPLOYER INFORMATION** Marital Status: S ___ M ___ W ___ SEP ___ D___

Mother's Name ______________________DOB_______________ SSN__________________Driver's Lic_________

Employer Name __________________Occupation__________________Cell______________ Work______________

Employer Address__________________________________________City/State/Zip___________________________

**FATHER'S EMPLOYER INFORMATION** Marital Status: S ___ M ___ W ___ SEP ___ D___

Father'sName ________________________DOB:_______________ SSN_____________Driver's Lic________

Employer Name ______________________Occupation____________Cell_________________ Work_____________

Employer Address__________________________________________City/State/Zip___________________________

**PERSON TO CONTACT IN CASE OF EMERGENCY (Other than parent)**

Name ____________________________Relationship ______________________________Phone _____________________

**INSURANCE –**

*** A copy of my insurance serves as valid proof of current insurance. I agree to notify and provide a copy of my insurance to KID-DOC Pediatrics upon any insurance changes that occur.**

**AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS**

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and other health plans to Shahzad A. Sheikh, M.D., P.A. dba KID-DOC Pediatrics. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to any parties necessary to secure payment and or to facilitate quality assurance. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I certify that the information I have provided with regard to my insurance coverage is correct. I have read and understand the HIPAA and Financial Policy in its entirety and agree to abide by ALL policies and procedures and be responsible for ALL charges and fees applicable to the services rendered at KID-DOC Pediatrics. I authorize being contacted by email/text for appointment reminders, balances, and or any notifications.

**Signature:**_____________________________________________________________**Date:**____________________

**Rev 09/2018** **(Patient, Parent, Guardian)** ***Attach copies: Insurance Card/Driver's License***