Liberty Sharonville Pediatrics
Patient Registration

Date: _____
Primary Provider: Dr. Brinn, Dr. Fernandez, Dr. Peck (*please circle one)*
Primary Office Location: Liberty Twp., Sharonville (*please circle one)*
Referred By: _____
Contact Email: _____
Contact Phone Numbers: Home: _____ Cell: _____

Children's Names:	Gender:	DOB:	SS#:

Race: _____ Ethnicity: _____
Preferred Language: _____ Religion: _____

Parent 1:
Name: _____ DOB: _____ SS#: _____
Relation to patient: _____
Address: _____ City, State, Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____ Employer: _____

Parent 2:
Name: _____ DOB: _____ SS#: _____
Relation to patient: _____
Address: _____ City, State, Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____ Employer: _____

Other Contacts (including step-parents, legal guardians and any emergency contacts):
Name: _____
Relation to patient: _____
Address: _____ City, State, Zip: _____
Phone: _____

Name: _____
Relation to patient: _____
Address: _____ City, State, Zip: _____
Phone: _____

Insurance Information:

Primary Insurance: _____ Plan phone number: _____
Claim mailing Address: _____
Subscriber (Insured Party): _____ Relation to patient: _____
SS#: _____ DOB: _____
Employer: _____
Policy number: _____ Group number: _____
Effective date: _____

Secondary Insurance: _____ Plan phone number: _____
Claim mailing Address: _____
Subscriber (Insured Party): _____ Relation to patient: _____
SS#: _____ DOB: _____
Employer: _____
Policy number: _____ Group number: _____
Effective date: _____

Preferred Pharmacy:

Name: _____ Address: _____
Phone: _____
Name: _____ Address: _____
Phone: _____

Authorization to Pay Physician Direct:

I authorize this physician to release any information acquired in the course of my examination or treatment and permit payment directly to him or her or her election, any benefits due me for his or her services rendered. I recognize and accept personal responsibility for any balance remaining after payment of such benefits.

Signed: _____ Date: _____

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