Liberty Sharonville Pediatrics, INC

7097 Liberty Centre Dr., West Chester, OH 45069
11258 Lebanon Road, Cincinnati, OH 45241

PATIENT REGISTRATION

Date:_____ Account Number:_____
Physician:_____ Information Taken By:_____
Referred By:_____ Home Telephone:_____

Dependent Information

Children's Names (list separately):	DOB:	Relationship to Responsible party:	Allergies:
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

Father's Name:_____Birth Date:_____SS #:_____
Address:_____City, State, Zip:_____
Home Phone:_____Cell Phone:_____Email Address:_____
Employer:_____Work Phone:_____Ext._____
Name of male step-parent (if applicable):_____
Legal male custodian (if applicable):_____
Custodial male parent (if applicable):_____

Mother's Name:_____Birth Date:_____SS #:_____
Address:_____City, State, Zip:_____
Home Phone:_____Cell Phone:_____Email Address:_____
Employer:_____Work Phone:_____Ext._____
Name of female step-parent (if applicable):_____
Legal female guardian (if applicable):_____
Custodial female parent (if applicable):_____

Family History (please check)

_____Asthma	_____Other Allergy	_____Tuberculosis	_____Diabetes
_____Birth Defects	_____Epilepsy	_____Migraine	_____Anemia
_____Bleeding Disorder	_____Heart Disease	_____Kidney Disease	_____Other

OVER

Primary Insurance_____
Claim Mailing Address_____
City, State and Zip_____
Effective Date of Coverage_____Subscriber's Date of Birth_____
Subscriber's Address (if different from patient's)_____
City, State and Zip_____
Social Security Number_____Relationship to Patient_____
Employer_____
Group # (Plan #)_____
Identification #_____

Secondary Insurance_____
Claim Mailing Address_____
City, State and Zip_____
Effective Date of Coverage_____Subscriber's Date of Birth_____
Subscriber's Address (if different from patient's)_____
City, State and Zip_____
Social Security Number_____Relationship to Patient_____
Employer_____
Group # (Plan #)_____
Identification #_____

Other Insurance Information (if applicable):_____
_____

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 (her), at his election, any benefits due me for his (her) services rendered. I recognize and accept personal responsibility for any balance remaining after payment of such benefits.

Signed:_____ Date:_____

WHO TO CALL IN CASE OF AN EMERGENCY (other than parent):
Name:_____
Address:_____
Telephone:_____ Relationship:_____