

Bethany Pediatrics, LLC.

Amaka J. Undie, M.D., F.A.A.P.

10300-A Baltimore National Pike, Ellicott City, MD 21042

PATIENT REGISTRATION FORM

I HEREBY AUTHORIZE THE PHYSICIAN TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING THIS ILLNESS/ ACCIDENT, AND I HEREBY IRREVOCABLY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE. A COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

DATE: _____

SIGNATURE OF SUBSCRIBER OR BENEFICIARY _____

PATIENT INFORMATION

First Name: Last Name:

Address:

City/State: Zipcode:

Phone: Email:

Date of Birth: Medical Record #

Sex: Male Female Social Security #:

Ins 1 Holder Ins 2 Holder

Ins 1 Co.: Ins 2 Co.:

Copay: \$ Policy #: Copay: \$ Policy #:

Patient Relationship to Cardholder: Self Parent Other

Patient Relationship to Cardholder: Self Parent Other

MOTHER'S INFORMATION

First Name: Last Name:

Address:

City/State: Zipcode:

Phone: Cell Phone:

Date of Birth: Social Security #:

Employer:

FATHER'S INFORMATION

First Name: Last Name:

Address:

City/State: Zipcode:

Phone: Cell Phone:

Date of Birth: Social Security #:

Employer:

Emergency Contact: Phone:

PREFERRED DRUGSTORE

Name: Phone:

Address:

City/State: Zipcode:

Who May We Thank For Referring You?