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: Email:

Date of Birth: Social Security #:

Employer:

FATHER'S INFORMATION

First Name: Last Name:

Address:

City/State: Zipcode:

Phone: Cell Phone: Email:

Date of Birth: Social Security #:

Employer:

Emergency Contact: Phone:

PREFERRED DRUGSTORE

Name: Phone:

Address:

City/State: Zipcode:

Who May We Thank For Referring You?