Oxford Pediatrics and Adolescents, Inc.
Patient Information
PLEASE NOTE: STEP PARENTS UNFORTUNATELY CANNOT FILL THIS REGISTRATION OUT

Patient Name________________________________ DOB____/____/____ M______ F________

Address______________________________ City__________________ State_________ Zip_____________

Phone ( ) ______________________________ Cell ( )__________________________

Patient Lives with _____Mom & Dad _____Mom _____ Dad _____Other please explain:______________________

Billing Information

Father's Name________________________________ DOB______/_______/____________

Address______________________________ City______________ State_____ Zip____________

Phone( )__________________ Cell ( )__________________ Employer______________________________

Marital Status (circle one) Single/Married/Divorced/Other____________/Spouse if other than Mother______________________

Mother's Name________________________________ DOB______/_______/____________

Address______________________________ City______________ State_____ Zip____________

Phone( )__________________ Cell ( )__________________ Employer______________________________

Marital Status (circle one) Single/Married/Divorced/Other____________/Spouse if other than Father______________________

Other Insured's Name________________________________ DOB______/_______/_________

Address______________________________ City______________ State_____ Zip____________

Phone( )__________________ Cell ( )__________________ Employer______________________________

Relationship to the Patient____

<u>Insurance Information</u> :In order to file insurance claims, we must have a copy of the insurance card

Please note: You are responsible to make us aware of all forms of insurance coverage. Copays are not billable they are due at the time of service. Any services not covered by your insurance will be billed directly to you with payment due within 30 days.

Primary Insurance______________________________ Subscriber Name/Relationship__________________________
DOB______________________________

Secondary Insurance______________________________ Subscriber Name/Relationship__________________________
DOB______________________________

I certify that I have received a copy of Oxford Pediatrics and Adolescents, Inc. Notice of Privacy Practices.

Signature:____

Signature below is authorization to file insurance by HFCA 1500 or Electronically. The signature is also validation that all of the information listed above is true and accurate to the best of your knowledge. I fully understand and agree to the above listed policies.

Signature parent/guardian:______________________________ Date _____/_____/______

Relationship to the patient____