Darien Pediatric Associates, LLC
DarienPediatrics.com

Family Registration Form

Primary Care Provider
__Dr. Tsimoyianis
__Dr. Dubaz
__Dr. Bader
__Dr. Shenoy

Parent #1 Name_____
Address_____
_____
City_____State_____Zip_____
Birth date__/__/__
Primary Phone#_____Other_____
Home#_____e-mail_____
Married__ Living Together__Widowed__
Divorced__ Custodial Parent_____

Parent #2 Name_____
Address_____
_____
City_____State_____Zip_____
Birth date__/__/__
Primary Phone#_____Other_____
Home#_____e-mail_____
Married__ Living Together__Widowed
Divorced__Custodial Parent_____

LIST ALL CHILDREN PATIENTS

Last Name	First Name	Sex	Date of Birth	Cell#	Insurance ID#
		M F			
		M F			
		M F			
		M F			
		M F			
		M F			

EMERGENCY CONTACT:
NAME _____ RELATIONSHIP _____ PH# _____

PHARMACY USED _____ LOCATION _____

PRIMARY INSURANCE _____ POLICY ID#_____GROUP# _____

NAME OF SUSCRIBER _____

EFFECTIVE DATE_____DEDUCTIBLE __YES__NO AMOUNT_____

PERSON RESPONSIBLE FOR BILL PAYMENT: _____

Authorization of Treatment and Assignment of Benefits: I authorize Darien Pediatrics, to treat my children. I further authorize the release of medical information necessary for the completion of insurance forms, school & camp forms. I authorize payment directly to Darien Pediatrics, for any and all medical or surgical benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse Darien pediatrics for any payments my insurance company may have sent to me in error. **I understand that I am financially responsible for all co-payments and any surcharges not covered under my insurance benefits.** I also understand that I am responsible for advising Darien Pediatrics of any and all changes to my insurance coverage. **Payment of co-pays and deductible are due on date of service.** Our office requires 24 hours notice of appointment cancellation. It is our policy that the person bringing the child to our office is responsible for payment of medical care. Failure to provide this notice will incur a $50.00 **cancellation fee.** There will be a $10.00 surcharge for any co-payment not paid at time of service. Please see our Financial Policy available in our office and website.

We are required by State and Federal laws, including the HIPAA Rules, to safeguard general and health-related information about our patients. We have created a Notice of Privacy Practices that explains how your protected health information is handled. The Notice of Privacy Practices is provided to patients (and/or their authorized representatives) when they first become our patient.

I acknowledge that Darien Pediatrics Associates, LLC has offered or provided me with a copy of its Financial, Office Policies, and Notice of Privacy Practices, which describes how medical information about me may be used and disclosed, and how I can access this information.

PRINT NAME_____SIGNATURE_____DATE_____