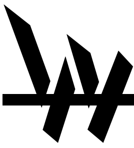

Waukesha Family Practice Clinic

CHILD REGISTRATION

237 Wisconsin Avenue, Waukesha, Wisconsin 53186-4955 • (262) 542-5557 Robert J. Beaumont, D.O.

DATE _____/_____/_____

Patient's Last Name ______ First ______ Middle ______ (Nickname) ______ Home Phone No. (______)-______

Social Security No. ____ ____ ____ - ____ ____ - ____ ____ ____ ____ Date of Birth ____/____/____ Age ______ Sex (circle one) M F

Street Address ______

City ______ State ______ Zip Code ______ Referred By: ______

Father's Last Name ______ First ______ Middle ______ Home Phone No. (______)-______

Father's Address ______ Cellular Phone No. (______)-______

Father's Social Security No. ____ ____ ____ - ____ ____ - ____ ____ ____ ____ Father's Date of Birth ____/____/____ E-mail Address ______

Father's Employer ______ Occupation ______ Working Hours ______ Business Phone No. (______)-______

Mother's Last Name ______ First ______ Middle ______ Home Phone No. (______)-______

Mother's Address ______ Cellular Phone No. (______)-______

Mother's Social Security No. ____ ____ ____ - ____ ____ - ____ ____ ____ ____ Mother's Date of Birth ____/____/____ E-mail Address: ______

Mother's Employer ______ Occupation ______ Working Hours ______ Business Phone No. (______)-______

Are any of your other children patients at this office? Yes No

Name of friend, neighbor, or relative we can reach in case of an emergency:

Other: Work or Cellular (______)-______

Name ______ Relationship to Patient ______ Home Phone No. (______)-______

INSURANCE INFORMATION

PRIMARY INSURANCE ______ Primary Insurance Address ______

Subscriber Name ______ Relationship ______

Subscriber Social Security No. ____ ____ ____ - ____ ____ - ____ ____ ____ ____ Subscriber Date of Birth ____/____/____

Subscriber/Policy No. ______ Group/Plan No. ______

Subscriber Employer ______

Co-Payment Amount ______ Effective Date of Ins. ______

SECONDARY INSURANCE ______ Secondary Insurance Address ______

Subscriber Name ______ Relationship ______

Subscriber Social Security No. ____ ____ ____ - ____ ____ - ____ ____ ____ ____ Subscriber Date of Birth ____/____/____

Subscriber/Policy No. ______ Group/Plan No. ______

Subscriber Employer ______

Co-Payment Amount ______ Effective Date of Ins. ______

Please Note: You are responsible to inform our office if pre-certification and/or referrals are required by your insurance company(s)

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I request that payment of authorized insurance benefits from any applicable insurance carrier be made on my behalf to Waukesha Family Practice Clinic, Ltd. for any services furnished me by that provider. I authorize medical information needed to determine these benefits or the benefits payable for the related services be released to the insurance company and its agents. **I understand that even though I have some type of insurance coverage, I am responsible for the payment of services.**

Please Note: It is the policy of this office that any parent who requests treatment for the child is responsible for the payment of all subsequent service fees.

X ______ *Signature of Parent Requesting Care* ____/____/____ *Date* **X** ______ *Witness* ____/____/____ *Date*

OTHER FAMILY MEMBERS AT YOUR ADDRESS

Name	Birth Date	Relationship	Name	Birth Date	Relationship