Pediatric Surgical Associates, P.A.
Registration Sheet

Account Number: _____ Date: _____

Patient's Full Legal Name: _____
Last First Middle Preferred Name

Billing Address: _____
Street City State Zip Code

Patient's Address: _____
Street City State Zip Code

Home Phone: ( ) _____ Age: _____ Birth Date: _____ Sex ____M ____F

Relative or close friend, not living with Patient: _____
(for emergency purposes) Name Relationship to Patient Phone

How did you hear about us? □ Physician Referral □ Friend / Family □ Internet □ Other _____

Referring Doctor (person): _____
Name **Address**

Patient's Primary Physician _____
Name **Address**

Were you first seen in the Emergency Room? _____
(Place/Date/Doctor)

Chief Complaint or Problem: _____

Allergies Weight

Medications

Parent / Guardian	**Parent / Guardian**
Name:	Name:
SS#:	SS#:
Relation to Patient:	Relation to Patient:
Address: Check if same as patient ( )	Address: Check if same as patient ( )
Home Phone#: ( )	Home Phone#: ( )
Cell Phone #: ( )	Cell Phone#: ( )
Email:	Email:
Employer:	Employer:
Business Phone:	Business Phone:

Primary Insurance: _____ Phone#: _____

Policy Number/SS# of Subscriber: _____ Group Name/ #: _____

Subscriber's name & DOB: _____

Secondary Insurance: _____ Phone#: _____

Policy Number/SS# of Subscriber: _____ Group Name/ #: _____

Subscriber's name & DOB: _____

PEDIATRIC
SURGICAL ASSOCIATES
GENERAL, THORACIC & MINIMALLY INVASIVE SURGERY
every child deserves our best

Daniel A. Bambini, MD
Andrew M. Schulman, MD
Graham H. Cosper, MD
Thomas M. Schmelzer, MD

Metroview Professional Building
1900 Randolph Road, Suite 210
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Telephone 704/370-0223
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www.pedsurgical.com

Duncan Morton, Jr., MD
Emeritus
Robert J. Attorri, MD
Emeritus
Amy J. Combs
Administrator

1. **AUTHORIZATION TO PAY BENEFITS**

   I understand that I am financially responsible for all charges and fees related to the treatment rendered to me by Pediatric Surgical Associates, P.A.

2. **AUTHORIZATION FOR THIRD PARTY PAYMENT**

   I, hereby, authorize assignment of benefits (insurance payment) to Pediatric Surgical Associates, P.A. for medical services rendered.

3. **AUTHORIZATION TO APPEAL INSURANCE BENEFITS**

   I, hereby, authorize Pediatric Surgical Associates to appeal insurance for any denials based on the particular plan's interpretation and data.

4. **AUTHORIZATION TO RELEASE INFORMATION**

   I, hereby, authorize Pediatric Surgical Associates, P.A. to furnish medical information as may be prescribed by the physician(s) in charge of this case.

I certify that I have read and fully understand the above.

_____
Parent or Guardian

_____
Patient Name

_____
Insurance Name and ID #

_____
Date

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PATIENT ACKNOWLEDGMENT AND CONSENT

I have been given a copy of Pediatric Surgical Associates P.A. Notice of Privacy Practices, version effective October 1, 2013. I consent to the uses and disclosures of my health information as outlined in the Notice.

_____ _____
Signature of Patient or Representative Date

_____
Print Name

_____
Relationship of Representative to Patient

Comments: _____

_____

_____

FOR OFFICE USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

_____

_____