PEDIATRIC PATIENT REGISTRATION

(Please Print)

MICHAEL J. O'NEILL M.D., PLLC.

1465 Kelly Johnson Blvd. Suite 310
Colorado Springs, CO 80920

Phone: 719-419-7490
Fax: 719-309-6847

Date: _____

Patient: _____
(Last Name, First Name, Middle Initial)

SSN: _____ Male: _____ Female: _____

Date of Birth: _____

Street Address/P.O. Box: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Cell Phone: _____

Parent/Guardian Information

Mother _____ Single Married Separated Divorced
(Last Name, First Name, Middle Initial)

Street Address/P.O. Box: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Business Phone: _____ City: _____ State: _____ ZIP Code: _____

Father _____ Single Married Separated Divorced
(Last Name, First Name, Middle Initial)

Street Address/P.O. Box: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Business Phone: _____ City: _____ State: _____ ZIP Code: _____

*If mother & father are not living together or if the child does not live with the parents, what is the child's custody status?

_____

In Case of Emergency, Please Contact:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Persons Authorized to Accompany and Provide Consent for Treatment Other Than Parents:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Preferred Pharmacy Name:

Location: _____ Phone: _____

Please List All Persons Living in the Child's Home:

Name	Relationship to Child	Date of Birth

Are there siblings not listed? If so, Please list their names, ages and where they live: _____

_____

_____

Name of Insured/Responsible Party: _____

Relationship to Patient: _____ SSN: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Street Address/P.O. Box: _____

City: _____ State: _____ Zip: _____

Name of Primary Insurer: _____

Contact #: _____ Group #: _____ Subscriber #: _____

Name of Secondary Insurer: _____

Contact #: _____ Group #: _____ Subscriber #: _____

I understand that payment of all medical care is due at the time of service. The parent and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance and/or unpaid balances not covered by insurance, regardless of marital status. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Michael O'Neill M.D., LLC. to release any pertinent information to my insurance company upon request and I also authorize payment directly to Michael O'Neill M.D., LLC.

A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Witness Date