PATIENT REGISTRATION

Lisa M. Asta, MD, Casa Verde Pediatrics, Inc.
301 Lennon Lane Ste 203
Walnut Creek, CA 94598

CHILD'S LAST NAME:_____FIRST NAME:_____ M.I:_____
CHILD'S STREET ADDRESS:_____
CITY:_____STATE:_____ZIP CODE:_____
HOME PHONE:( )_____BIRTHDATE: MONTH_____DAY_____YEAR_____
SEX:_____MALE _____FEMALE SOC. SEC # _____-_____-_____
IN CASE OF EMERGENCY, NOTIFY:_____PHONE:_____

PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN #1:_____ADDRESS (IF DIFFERENT):_____
HOME PHONE:( )_____WORK PHONE:( )_____
CELL PHONE:( )_____RELATION:_____SS#:_____
EMAIL:_____

PARENT/GUARDIAN #2:_____ADDRESS(IF DIFFERENT):_____
HOME PHONE:( )_____WORK PHONE:( )_____
CELL PHONE:( )_____RELATION:_____SS#:_____
EMAIL:_____

INSURANCE INFORMATION

PRIMARY INS:_____POLICY #:_____
GROUP #:_____EFFECTIVE DATE:_____
MARITAL STATUS:___SINGLE___MARRIED___DIVORCED___WIDOWED___OTHER
STUDENT STATUS:____FULL-TIME____PART-TIME
POLICY HOLDER NAME, IF DIFFERENT THAN ABOVE:_____
YOUR RELATIONSHIP TO INSURED:____SELF____SPOUSE____CHILD____OTHER
REFERRING PROVIDER:_____
SECONDARY INS:_____POLICY #:_____
GROUP #:_____EFFECTIVE DATE:_____
POLICY HOLDER NAME, IF DIFFERENT THAN ABOVE:_____
YOUR RELATIONSHIP TO INSURED:____SELF____SPOUSE____CHILD____OTHER

PREFERRED PHARMACY

NAME:_____ ADDRESS:_____
PHONE:_____ FAX:_____

FINANCIAL AGREEMENT & RELEASE OF INFORMATION

Casa Verde Pediatrics will bill certain insurance plans in which we are a participating provider. Patients are required to pay applicable co-payments at the time of service. When we are notified by your insurance carrier(s) of any non-covered services, deductibles, or additional co-payments, we will send you a bill. You are required to pay this bill upon receipt. Please remember that this is a courtesy to you and that our billing your insurance plan does not release you of the financial responsibility of your medical services. I understand that I am financially responsible to Casa Verde Pediatrics for all charges incurred. I authorize Casa Verde Pediatrics to furnish information from my records to any insurer of mine. Further, I authorize payment to Casa Verde Pediatrics of the health insurance benefits otherwise payable to me, but not to exceed the regular charges for this period of care. I understand that I am financially responsible to Casa Verde Pediatrics for the charges not paid by my insurance plan(s).

Signature:_____Date:_____