Genesee-Transit Pediatrics

Registration Form-Patients 18yrs & older

In order to serve you properly, we will need this form completed. All information is confidential.

Patient Email:_____

Patient Name: _____ Birth Date: _____

Sex: ◯ Male / ◯ Female (please select one) **Phone: (_____) _____**

Address: _____City:_____ State: _____Zip code: _____

Primary Language: _____ Country: _____
Secondary Language: _____ Country: _____
Ethnicity: Spanish/Hispanic: ___◯___ Not of Spanish/Hispanic: ___◯___ Declined/Unknown___◯___
Ancestry: ___☐___ Asian ___☐___ American Indian/ Alaska Native ___☐___ Black/ African American
___☐___ Native Hawaiian/Pacific Islander ___☐___ White ___☐___ Other ___☐___ Declined/Unknown

Pharmacy: _____Phone: (____)_____

Patient's Employer (if any): _____Phone: (____)_____

Emergency Contact

***Please note-this does not allow the emergency contact to have access to medical or billing information whenever they call. This is to get a message to you if we have do not have any other way to get a hold of you.**

1) _____/_____ 2) _____/_____
Name/Relationship Phone number Name/Relationship Phone number

Insurance Information

Are you under your parent's insurance?: ◯ N/A ◯ Yes ◯ No ◯ I have my own coverage
(please select one of the above)

Primary Insurance Company: _____
Policy #: _____ Group #: _____
Name of Subscriber: _____ Birth Date: _____

It is your responsibility to provide accurate and up to date medical insurance information to us and to notify us of any changes in your insurance coverage. You will be invoiced directly if your insurance denies coverage or if we do not have insurance changes/information that results in a timely filing denial.
You are responsible for and expected to pay promptly all copayments, coinsurance or unpaid deductibles at the time of service.

I, the undersigned, authorize the release of any medical or insurance information to the stated insurance company necessary to process insurance claims for the services rendered by the practitioners of Genesee-Transit Pediatrics, LLP. I hereby authorize the above insurance company to distribute the payment of my medical coverage directly to the provider rendering services.

_____ Date _____
(Signature)