Holly S. DiMeglio, ANP, RN

Advanced Nurse Practitioner–Pediatric/Psychiatric Specialty

OFFICE REGISTRATION FORM

PLEASE FILL OUT COMPLETELY

Child's Name:_____DOB:_____ Male Female

Physical home address:_____
(City) (State) (ZipCode)

Home Phone #:_____ Child's SSN#:_____

1ST Guardian's Name:_____ DOB:_____

Relationship to Child:_____ SSN#:_____

Mailing address:_____
(City) (State) (ZipCode)

Home Phone #:_____ Work Phone #:_____

Cellular Phone #:_____ Which # is best?_____

2ND Guardian's Name:_____ DOB:_____

Relationship to Child:_____ SSN#:_____

Mailing address:_____
(City) (State) (ZipCode)

Home Phone #:_____ Work Phone #:_____

Cellular Phone #:_____ Which # is best?_____

Who Is the Child's Primary Care Provider?_____ Last Seen :_____

Who Referred You To See Holly S. DiMeglio?_____

FORM OF PAYMENT FOR SERVICES

If you have insurance cards please give them to the receptionist for copying.

PRIMARY INSURANCE INFORMATION:

Insurance Company Name: _____

Claims Address:_____

Policy Holder's Name:_____ Relationship to Client:_____

Policy I.D. Number:_____ Group I.D.:_____

Policy Holder's SSN#:_____ DOB:_____

Holly S. DiMeglio, ANP, RN
Advanced Nurse Practitioner—Pediatric/Psychiatric Specialty
8717 Dimond D Circle Anchorage, Alaska 99515
Office 907.644.3968 Facsimile 907.644.3969

FORM OF PAYMENT FOR SERVICES

If you have insurance cards please give them to the receptionist for copying.

SECONDARY INSURANCE INFORMATION:

Insurance Company Name: _____

Claims Address:_____

Policy Holder's Name:_____ Relationship to Client:_____

Policy I.D. Number:_____ Group I.D.:_____

Policy Holder's SSN#:_____ DOB:_____

I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ANY AND ALL CHARGES FOR SERVICES RENDERED TO ME OR MY CHILD BY HOLLY S. DIMEGLIO,ANP. MY INSURANCE WILL BE BILLED AS A COURTESY TO ME ONLY IF I PROVIDE ACCURATE INSURANCE INFORMAION TO MS. DIMEGLIO. I AM RESPONSIBLE FOR ANY PORTIONS OF MY BILL AT THE TIME THAT SERVICES ARE RENDERED, UNLESS INSURANCE IS PREDETERMINED TO COVER IT BYMS. DIMEGLIO. I HERBY AUTHORIZE PAYMENT BY MY INSURANCE DIRECTLY TO MS. DIMEGLIO. I FURTHER AUTHORIZE RELEASE BY HOLLY S. DIMEGLIO,ANP OF ANY INFORMATION NECESSARY TO MY INSURACE COMPANY FOR PAYMENT OF CLAIMS.

_____ _____
(GUARDIAN OR PATIENT SIGNATURE—PLEASE SPECIFY) **(DATE)** **1ST YR**

_____ _____
(GUARDIAN OR PATIENT SIGNATURE—PLEASE SPECIFY) **(DATE)** **2ND YR**

_____ _____
(GUARDIAN OR PATIENT SIGNATURE—PLEASE SPECIFY) **(DATE)** **3RD YR**