

DATE _____

PATIENT REGISTRATION

 FOR INTERNAL USE ONLY
 PATIENT NUMBER _____

PATIENT INFORMATION (If more than one child use second page)

 SOCIAL SECURITY # _____
 FIRST NAME _____ MIDDLE _____
 LAST NAME _____
 SEX _____ DATE OF BIRTH ____/____/____
 (CHECK ONE) EMPLOYED FULL TIME STUDENT
 OTHER _____

 HOME ADDRESS _____
 CITY _____ STATE _____ ZIP _____
 EMAIL _____
 HOME PHONE (____) _____
 WORK PHONE (____) _____
 HOW DID YOU HEAR OF US? _____

RESPONSIBLE PARTY / GUARANTOR

 SOCIAL SECURITY # _____
 RELATIONSHIP _____
 FIRST NAME _____ MIDDLE _____
 LAST NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP _____
 EMAIL _____

 SEX _____ DATE OF BIRTH ____/____/____
 HOME PHONE (____) _____
 CELL PHONE (____) _____
 DAYTIME PHONE (____) _____
 EMPLOYER _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP _____

INSURANCE INFORMATION PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST
 COMMERCIAL MEDICAID MEDICARE CAREFIRST BC/BS OTHER _____
 INSURANCE COMPANY _____ COPAY \$ _____
 INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP _____ DOB _____
 POLICY # _____ GROUP # _____ PHONE (____) _____

SECONDARY INSURANCE INFORMATION
 COMMERCIAL MEDICAID MEDICARE CAREFIRST BC/BS OTHER _____
 INSURANCE COMPANY _____ COPAY \$ _____
 INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP _____ DOB _____
 POLICY # _____ GROUP # _____ PHONE (____) _____

SUBSCRIBER INFORMATION
 CHECK IF SAME AS RESPONSIBLE PARTY/GUARANTOR

 SOCIAL SECURITY # _____
 RELATIONSHIP _____
 FIRST NAME _____ MIDDLE _____
 LAST NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP _____
 EMAIL _____

 SEX _____ DATE OF BIRTH ____/____/____
 HOME PHONE (____) _____
 CELL PHONE (____) _____
 DAYTIME PHONE (____) _____
 EMPLOYER _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP _____

OTHER PARENT INFORMATION / LEGAL GUARDIAN INFORMATION

 CHECK IF SAME AS : GUARANTOR SUBSCRIBER

 FIRST NAME _____ MIDDLE _____ LAST NAME _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 RELATIONSHIP TO PATIENT _____ EMAIL _____
 WORK PHONE (____) _____ HOME PHONE (____) _____ CELL (____) _____

EMERGENCY CONTACT (SOMEONE OTHER THAN PARENT)

 RELATIONSHIP TO PATIENT _____ SEX _____
 FIRST NAME _____ MIDDLE _____ HOME PHONE (____) _____
 LAST NAME _____ WORK PHONE (____) _____

If insurance information or home address is different for any family member a new registration sheet should be completed for that member

PATIENT INFORMATION

SOCIAL SECURITY # _____
FIRST NAME _____ MIDDLE _____
LAST NAME _____
SEX _____ DATE OF BIRTH ____/____/____

(CHECK ONE) EMPLOYED FULL TIME STUDENT
 OTHER _____

PLEASE CHECK IF ADDRESS IS SAME AS ON FRONT HOME ADDRESS _____
CITY _____ STATE _____ ZIP _____
EMAIL _____
HOME PHONE (____) _____

PATIENT INFORMATION

SOCIAL SECURITY # _____
FIRST NAME _____ MIDDLE _____
LAST NAME _____
SEX _____ DATE OF BIRTH ____/____/____

(CHECK ONE) EMPLOYED FULL TIME STUDENT
 OTHER _____

PLEASE CHECK IF ADDRESS IS SAME AS ON FRONT HOME ADDRESS _____
CITY _____ STATE _____ ZIP _____
EMAIL _____
HOME PHONE (____) _____

PATIENT INFORMATION

SOCIAL SECURITY # _____
FIRST NAME _____ MIDDLE _____
LAST NAME _____
SEX _____ DATE OF BIRTH ____/____/____

(CHECK ONE) EMPLOYED FULL TIME STUDENT
 OTHER _____

PLEASE CHECK IF ADDRESS IS SAME AS ON FRONT HOME ADDRESS _____
CITY _____ STATE _____ ZIP _____
EMAIL _____
HOME PHONE (____) _____

PATIENT INFORMATION

SOCIAL SECURITY # _____
FIRST NAME _____ MIDDLE _____
LAST NAME _____
SEX _____ DATE OF BIRTH ____/____/____

(CHECK ONE) EMPLOYED FULL TIME STUDENT
 OTHER _____

PLEASE CHECK IF ADDRESS IS SAME AS ON FRONT HOME ADDRESS _____
CITY _____ STATE _____ ZIP _____
EMAIL _____
HOME PHONE (____) _____

Assignment and Release

I the undersigned certify that I (or my dependent) have insurance coverage with _____, and assign directly to Children's Pediatricians & Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize, Children's Pediatricians & Associates to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I further agree to pay any collections and/or legal fees necessary for collections, if such situation was to arise.

(Responsible Party Signature)

(Relationship)

Date _____

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects patient privacy. Children's Hospital complies with HIPAA and provides a Notice of Privacy Practices to patients to let them know how we disclose information to whom and under what circumstances, the rights of patient and methods of reporting complaints. Under the HIPAA guidelines we use information for payment, treatment and healthcare operations. For more information, consult the Notice of Privacy Practices.