

Community Care Physicians, P.C. Pediatric Patient Registration Form

Date: _____

Patient ID#: _____
(for office use only)

PATIENT INFORMATION

Social Security Number _____ / _____ / _____ (Providing your SSN is optional. However, for patients with certain insurances this information may help us determine eligibility for certain health benefits).

LAST NAME: _____ FIRST NAME: _____ MI: _____

Legal Name: _____ Preferred Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Home Phone #: () _____

Cell #: () _____ Preferred daytime phone: Home Work Cell

Date of Birth: _____ / _____ / _____ Gender: Male Female Other _____

E-mail Address: _____ Would you like to participate in the patient portal?
 Yes No

It is known that some medical conditions such as high blood pressure and osteoporosis, tend to have a higher incidence in certain ethnic groups. Therefore, we ask that you please provide us with information regarding your race and ethnicity so we can assess if you are at increased risk for the development of these conditions.

Race: Select one
 American Indian/Alaska Native
 Asian
 Native Hawaiian or other Pacific Islander
 Black/African American
 White
 Other

Ethnicity: Select One
 Hispanic/Latino
 Not Hispanic/Latino

Preferred Language: _____

Emergency Contact: _____ Emergency Contact DOB: _____ / _____ / _____

Emergency Phone: () _____ Relationship to Patient: _____

Mother's maiden name _____

First Name Maiden Name

Primary Care Physician: _____ **Referring Physician:** _____

In addition to telephone, which other methods of communication are acceptable? Please check all that apply

E-Mail (when available) Text Office may leave a message at home

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FINANCIALLY RESPONSIBLE PARTY

In accordance with Community Care Physicians' Financial Policy, this is defined as the adult accompanying a child under the age of 18, and/or the parent or guardian of the child. This is the person who will receive bills and correspondence. **Co-pays are due and expected at time of service.**

Financially Responsible Parent/Guardian's Last Name _____ First _____

Relationship to Patient Mother Father Other: _____

Address Same as Above Street: _____ City/State/Zip _____

Home Phone # () _____ Work Phone # () _____ Cell Phone # () _____

Date of Birth ___/___/___ Guarantor: Yes No

Other Parent/Guardian's Last Name _____ First _____

Relationship to Patient: Mother Father Other _____

Address Same as Above Street: _____ City/State/Zip _____

Home Phone # () _____ Work Phone # () _____ Cell Phone # () _____

Date of Birth ___/___/___ Guarantor: Yes No

MEDICAL INSURANCE INFORMATION

(The subscriber is the same person as the policy holder)

Primary Insurance: _____ Subscriber's Name: _____

Subscriber's Date of Birth: ___/___/___ Relationship to Subscriber: Self Spouse Child Other _____

Co-pay: \$ _____ Policy ID # _____ Group #: _____

Secondary Insurance: _____ Subscriber's Name: _____

Subscriber's Date of Birth: ___/___/___ Relationship to Subscriber: Self Spouse Child Other _____

Co-pay: \$ _____ Policy ID #: _____ Group #: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, when they accept assignment.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize my Provider, to release any information necessary for my course of treatment.

Signature of Patient / Guardian

_____/_____/_____
Date