CAPE COD PEDIATRICS, LLP

Patient Registration Form

Date Information Taken_____ Patient lives with: Mother, Father, Both Other (Circle one)

Patient Name: _____ DOB: _____ Sex M F

Mailing Address: _____ Home Phone _____

Town: _____ State: _____ Zip Code _____

Father's Name: _____ DOB: _____

Address if different _____ Home Phone # _____

Town: _____ State _____ Zip Code _____

Work Phone # _____ Cell Phone # _____

Mother's Name: _____ DOB: _____

Address if different _____ Home Phone # _____

Town: _____ State: _____ Zip Code: _____

Work Phone # _____ Cell Phone # _____

Child's Insurance: _____ ID# _____
Company Name

Subscriber Name: _____

Person responsible for payment: _____

Preferred Pharmacy: _____

Other Guardian _____ **Relationship** _____

Assignment of Benefits and Release of Information:

I hereby authorize Cape Cod Pediatrics, LLP to release any information necessary to process my insurance claim, to allow a photocopy of my signature to be used to process my insurance claim for the period of a lifetime. I authorize and direct my carrier to issue payment directly to Cape Cod Pediatrics, LLP. Regardless of my insurance benefits, if any, I understand that I am fully financially responsible for any and all fees incurred. And I agree to pay such fees in full. Additionally, I agree to obtain a referral from my primary physician and agree to pay all claims if denied. I authorize treatment to be given by the providers of Cape Cod Pediatrics, LLP and covering providers to my child when accompanied by myself or by a caregiver other than myself. **Failure to remit payment within 90 days will jeopardize your patient status.**

_____ _____

Parent/Guardian Signature Date

Office Use Only:

LST____FPA____Other_____

No update needed , Date: _____, Initials: _____

Date: _____, Initials: _____

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