CAPE COD PEDIATRICS
PATIENT REGISTRATION

Last Name: ________________**First Name:** ________________ **Middle:** ________________

Date of Birth: __________ Sex: M F Primary Language if not English: ____________________

Mailing Address Street: ____

City: ______________State: ________Zip Code: ______________________________

Home Address (If Different from Mailing) Street: __________________________________

City: ______________State: ________Zip Code: ______________________________

Race (Optional): __________________ Ethnicity (Optional): ________________________

Patient's Cell: ____

Father__ /Guardian__: Last Name: ____________________**First Name:**________________

DOB: __________ Social Security No: ________________Drivers Lic No: ________________

Address if Different than above: Street: ____

City: __________________ State: __________ Zip Code: ____________________________

E-Mail: ____

Phone: Home: ____________________ Work: ______________________________

Cell: __________________________ Please Circle Preferred Contact Number

Mother __/Guardian ___ :Last Name: ____________________**First Name:**______________

DOB: __________ Social Security No: ________________Drivers Lic No: ________________

Address if Different than above: Street: ____

City: __________________ State: __________ Zip Code: ____________________________

E-Mail: ____

Phone: Home: ____________________ Work: ______________________________

Cell: __________________________ Please Circle Preferred Contact Number

If Guardian is Other than mother/father, Legal documentation must be provided

PLEASE COMPLETE NEXT PAGE

Siblings: ____

Primary Insurance Company Name: ________________________________

Insurance ID#: ______________________Group No: ________________

Subscriber's Name: ____Cape

Secondary Insurance Co. Name: ___________________________________

Insurance ID#: ______________________Group No: ________________

Subscriber's Name: ____

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Assignment of Benefits and Release of Information:

I hereby authorize Cape Cod Pediatrics, LLP (CCP) to release any information necessary to process my insurance claim. I agree to furnish CCP with a copy of my current health insurance card(s). I authorize and direct my carrier to issue payment directly to CCP. Regardless of my insurance benefits, if any, I understand that I am fully financially responsible for any and all fees incurred. I agree to pay such fees in full. I agree that it is my responsibility to provider CCP with current insurance information and in not doing so within the time limitations set by my insurance company for claim submission, understand that I will be fully financially responsible for those charges. Additionally, I agree to obtain a referral from my primary physician if required and agree to pay all claims if denied.

I authorize treatment to be given by the providers of CCP 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 patient status.

Notice of Privacy Practices Acknowledgement and Consent

By signing below I acknowledge I have received/read a copy of Cape Cod Pediatrics HIPAA Privacy Practices and therefore have been advised how health info about me may be used and disclosed by them, and how I may obtain access to and control of this information.

Notice of Medication History Authority

Cape Cod Pediatrics is required to obtain my consent in order to access a list of my past prescription medications from my pharmacy, health plans, or my other healthcare providers. By signing below I agree to this consent and understand it will not terminate or expire unless I deliver notice of such termination to the Practice.

Parent/Guardian Signature: ____________________________ **Date:** __________

Print Name: ____