CAPE COD PEDIATRICS

Patient Registration

Last Name: _____ First Name: _____ MI: _____

Date of Birth: ____/____/____ Sex: M F Primary Language (if not English): _____

Race (Optional): _____ Ethnicity (Optional): _____

Mailing Address: Street/PO Box: _____ City: _____

State: _____ Zip Code: _____

Home Address (If different than mailing): Street _____

City: _____ State: _____ Zip Code: _____

E-Mail for Patient Portal: _____

Emergency Contact: Last Name: _____ First Name: _____

Relationship: _____ Phone No: _____

Father___ Guardian ___ Last Name: _____ First Name: _____

DOB: ____/____/____ Social Security No: _____/____/_____ DL No: _____ State_____

Address if different than above: Street/PO Box: _____

City: _____ State: _____ Zip Code: _____

Phone: Primary No: _____ Secondary No: _____

Mother ___ Guardian ___ Last Name: _____First Name: _____

DOB: ____/___/____ Social Security No: ____/____/_____ DL No: _____ State _____

Address if different than above: Street/PO Box_____

City: _____ State: _____Zip Code: _____

Phone: Primary No: _____ Secondary No _____

***Legal documentation is required if legal guardian is other than parent.**

PLEASE COMPLETE PAGE 2

Siblings: _____

Primary Insurance: _____

Insurance ID#: _____ Group #: _____

Subscriber's Name: _____ DOB: ____/____/___

Secondary Insurance (If applicable): _____

Insurance ID#: _____ Group #: _____

Subscriber's Name: _____ DOB: ____/____/____

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 fees incurred. I agree to pay such fees in full. I agree that it is my responsibility to provide CCP with my current insurance information, and in not doing so within the time limitations set by my insurance company for claim submission, I understand that I will be fully financially responsible for those charges.

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 that I have received/read a copy of CCP's HIPAA Privacy Practices, and therefore have been advised how health info about my child may be used and disclosed by them, and how I may obtain access to and control of this information.

Notice of Medication History Authorization:

CCP is required to obtain my consent in order to access a list of my child(ren's) past prescription medication 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: _____
***If guardian, please provide legal documentation**