

Cape Fear Pediatrics, P.A.
Patient Registration Form

Acct. No. _____

Date ____ / ____ / ____

Patient Information

Date of Birth ____ / ____ / ____ Sex: M F SSN# _____

Last Name _____ First _____ Middle Initial _____

Address _____ Home Phone _____

City/State/Zip _____ Cell Phone _____

Child Lives With: Mother Father Guardian Other _____

Sibling: _____ Date of Birth ____ / ____ / ____ M F

Sibling: _____ Date of Birth ____ / ____ / ____ M F

Sibling: _____ Date of Birth ____ / ____ / ____ M F

Emergency Contact _____ Relationship _____ Phone _____

Guarantor Information

Mother's Last Name _____ First _____ DOB ____ / ____ / ____

Address (if different from patient) _____ SSN # _____

City/State/Zip _____ Home Phone _____

Employer _____ Work Phone _____

Address _____ City/State/Zip _____

Father's Last Name _____ First _____ DOB ____ / ____ / ____

Address (if different from patient) _____ SSN # _____

City/State/Zip _____ Home Phone _____

Employer _____ Work Phone _____

Address _____ City/State/Zip _____

Insurance Information (Copy of current insurance card required)

Primary Ins. _____ Claims Address _____

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

Secondary Ins. _____ Claims Address _____

Policy # _____ Group # _____

Name of Policyholder _____ Relationship to Patient _____

Physician Listed on Card _____ Phone _____

*** Payments and co-pays are to be paid at the time of service. We require a current copy of your insurance card at each visit. If insurance information is not provided at the time of service, payment is required in full, unless prior financial arrangements have been made with our insurance department.

(OVER)

Please read and sign our authorization for treatment and benefits on the back of this form.

Authorization of Treatment and Assignment of Benefits

I authorize Cape Fear Pediatrics, P.A. to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Cape Fear Pediatrics, P.A. for all medical benefits otherwise payable to me under the terms of my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. If insurance is unable to be filed, I understand that I am to pay at the time services are rendered. I understand that sixty days from the date of service, whether insurance has made payment or not, I am responsible for the balance. I certify that the information I have reported with regard to my insurance company and responsible party is correct.

I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented for testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Parent/Guardian's Signature _____ Relationship _____

Date _____ Witness _____