PATIENT REGISTRATION FORM

PATIENT (CHILD) INFORMATION

Name

Address

City, State, Zip

Home Telephone (   ) County

Date of Birth CHILD'S Social Security Number

Sex (Check One) ☐ M ☐ F

Race (Check One) ☐ Asian (A) ☐ Black (B) ☐ Caucasian (C) ☐ Hispanic (H) ☐ Native American (I) ☐ Other

Patient's Primary Language: English Spoken? ☐ Yes ☐ No

PARENTAL/BILLING INFORMATION

	MOTHER'S INFORMATION	FATHER'S INFORMATION	LEGAL GUARDIAN'S INFORMATION
Name			
Address			
City, State, Zip			
Home Telephone			
Social Security #			
Date of Birth			
Employer			
Employer's Address			
City, State, Zip			
Work Telephone			

Guarantor's primary language: English Spoken? ☐ Yes ☐ No

With whom does the patient reside? (Check One) ☐ Mother ☐ Father ☐ Both Parents ☐ Legal Guardian ☐ Other – please specify:

REFERRAL SOURCE (How did you hear about our practice?)

Name

INSURANCE INFORMATION

Insurance Company Name		
Group Name/Number		
Policy Number		
Policyholder Name (Subscriber)		
Patient Relationship to Policyholder		

☐ Please check this box if the patient has more than two forms of insurance and complete the same information as requested for the primary/secondary insurance on the back of this form. How will you be paying your portion today? ☐ Cash ☐Check ☐Credit Card

EMERGENCY CONTACT INFORMATION (Other than parent or legal guardian)

Name

Telephone Number (   ) Relationship to Patient

Have you ever applied for Medicaid? ☐Yes ☐No

Would you like to apply for Medicaid? ☐Yes ☐No

I authorize payment of medical benefits to Cartersville Pediatric Associates and I authorize the release of any medical information necessary to process insurance claims. I voluntarily consent to examination and treatment for myself and/or my dependents. I will be responsible for the full amount of the charges except those under Cartersville Pediatric Associates contractual arrangements with certain insurers.

Parent/Responsible Person: ______________________________ Date: ______________

In absence of Parent/Responsible Person, sign here: ______________________ Date: ______________