Mt. Airy Pediatrics, P.C.
Patient Registration Form

We CANNOT accept this form unless you fill out both pages as completely and thoroughly as possible.

Patient(s) NAME ____
Last **First** **MI** **DOB** **SS#** **Sex**

____
Last **First** **MI** **DOB** **SS#** **Sex**

____
Last **First** **MI** **DOB** **SS#** **Sex**

____
Last **First** **MI** **DOB** **SS#** **Sex**

ADDRESS ____

City _________________________________ **State** _____ **Zip** _______ **Phone #**____________________

Please share information about your race, ethnicity and preferred language with us. The Center for Medicare and Medicaid Services requires that we keep this information on file. Thank you!

RACE (Please select all that apply): ___ American Indian or Alaska Native ___ Asian American ___ Black or African American ___ Hispanic or Latino ___ Native Hawaiian or Other Pacific Islander ___ White ___ Multiracial ___ Other (please specify): __________________

ETHNICITY: ___ Central American ___ Cuban ___ Dominican ___ Hispanic or Latino ___ NOT Hispanic or Latino ___ Mexican ___ Puerto Rican ___ Spaniard ___ Other (please specify): __________________

PREFERRED LANGUAGE (Please select all that apply): ___ English ___ Spanish ___ French ___ Portuguese ___ Chinese ___ Hebrew ____ Other (please specify): __________________________

If you would prefer NOT to provide us with this information, please initial here ____________.

Parent/Legal Guardian
NAME ______________________**Relationship to child**_____________ **Birthdate** _____________**SS#**__________________

Address __________________________________ **City** __________________________________ **State** ______ **Zip** _______

Phone# ____________________________________ **email address** ____

Employer ___________________________**Work Phone#**______________________**Beeper/Cell#**_________________________

Parent/Legal Guardian
NAME ______________________**Relationship to child**_____________ **Birthdate** _____________**SS#**__________________

Address __________________________________ **City** __________________________________ **State** ______ **Zip** _______

Phone# ____________________________________ **email address** ____

Employer ___________________________**Work Phone#**______________________**Beeper/Cell#**_________________________

(If Applicable)
Non-custodial Caretaker
NAME ______________________**Relationship to child**_____________ **Birthdate** _____________**SS#**__________________

Address __________________________________ **City** __________________________________ **State** ______ **Zip** _______

Phone# ____________________________________ **email address** ____

Employer ___________________________**Work Phone#**______________________**Beeper/Cell#**_________________________

IN CASE OF EMERGENCY CALL: _______________________**Relationship:** _________________ **Phone#** ___________________

_______________________**Relationship:** _________________**Phone#** ___________________

Nearest relative not living with you: ____ **Phone#** _________________________

Pharmacy name and phone#________________________________
Pharmacy location____________________________________
(Unless you specify otherwise when you call, this is the number we will use if we ever need to call in a prescription. It is your responsibility to update this information with us.)

INSURANCE INFORMATION

Please make sure to provide the office staff with a copy of both sides of your health insurance card. It is your responsibility to advise us of any changes in your insurance coverage (including co-pay changes) as soon as they occur, in order for the billing process to go as smoothly as possible.

Primary Health Insurance Coverage

INSURANCE Co. Name ______________________________

Insurance Co. Address_________________________________ City _________________State ____Zip ____________

Tel#____________________________________

ID# ____________________________________ Group # ____________________ Co-pay _______________

Subscriber Name ______________________Subscriber's birthdate _____________Subscriber SS# ____________________

Subscriber's Relationship to child ____________Is child covered? Yes _____ No ______

Address ________________________________City __________________________________ State ______ Zip _______

Home Phone# _______________________Work Phone#______________________Beeper/Cell#_________________________

Secondary Health Insurance Coverage

INSURANCE Co. Name ______________________________

Insurance Co. Address______________________________

Tel#____________________________________

ID# ____________________________________ Group # ____________________ Co-pay _______________

Subscriber Name __________________________Subscriber's birthdate ________________Subscriber SS# _________________

Subscriber's Relationship to child ______________________Is child covered? Yes _____ No ______

Address _______________________________________ City ____________________________ State ______ Zip _______

Home Phone# _________________________Work Phone#______________________Beeper/Cell#_________________________

___

In order to control our billing costs, payment is expected when services are rendered.

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits to Mt. Airy Pediatrics. **I understand that I am financially responsible for any balance not covered by my insurance carrier**. A copy of this signature is as valid as the original.

Signature: ____ Date: _____________________
This form MUST signed and it is your responsibility to update your information with us as soon as it changes.