

CapitalCare Medical Group CHILD Patient Registration Form

Date: _____

Patient ID#: _____

PATIENT INFORMATION

(for office use only)

Social Security Number _____/_____/_____ (Providing your SSN is optional. However, for patients with Medicare and/or Medicaid having this information may help us determine eligibility for certain health benefits).

LAST NAME: _____ FIRST NAME: _____ MI: _____

E-mail Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Home Phone #: () _____

Work #: () _____ Cell #: () _____ Preferred daytime phone: Home Work Cell

Date of Birth: ____/____/____ Marital Status: Single Married Widowed Divorced

Gender: Male Female

It is known that some medical conditions such as high blood pressure and osteoporosis, tend to have a higher incidence in certain ethnic groups. Therefore we ask that you please provide us with information regarding your race and ethnicity so we can assess if you are at increased risk for the development of these conditions.

Race: Select one

- American Indian/Alaska Native Asian
 Native Hawaiian or other Pacific Islander
 Black/African American White
 Other

Ethnicity: Select One

- Hispanic/Latino
 Not Hispanic/Latino

Preferred Language: _____

Emergency Contact: (Other than parents) _____ Relationship to Patient: _____

Emergency Phone #1: () _____ Phone #2: () _____

Mother's maiden* _____ Primary Care Physician: _____
First Maiden Last (in our Practice)

In addition to telephone, which other methods of communication are acceptable? Please check all that apply

E-Mail (when available) Confidential Fax _____ Office may leave a message at home

FINANCIALLY RESPONSIBLE PARTY

In accordance with CapitalCare's Financial Policy, this is defined as the adult accompanying a child under the age of 18, and/or the parent or guardian of the child. This is the person who will receive bills and correspondence. Co-pays are due and expected at time of service.

Financially Responsible Parent/Guardian's Last Name: _____ First: _____

Relationship to Patient: Mother Father Other _____

Address: Same as Above _____ City/State/Zip: _____

Home Phone #: () _____ Work Phone#: () _____ Cell Phone#: () _____

Date of Birth _____

Other Parent/Guardian's Last Name: _____ First: _____

Relationship to Patient: Mother Father Other _____

Address: Same as Above _____ City/State/Zip: _____

Home Phone #: () _____ Work Phone#: () _____ Cell Phone#: () _____

Date of Birth _____

*Required for NYS Immunization Registry

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MEDICAL INSURANCE INFORMATION

(The subscriber is the same person as the policy holder)

Primary Insurance: _____ Subscriber's Name: _____

Subscriber's Date of Birth: ___/___/___ Relationship to Subscriber: Self Spouse Child Other _____

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

Secondary Insurance: _____ Subscriber's Name: _____

Subscriber's Date of Birth: ___/___/___ Relationship to Subscriber: Self Spouse Child Other _____

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

INSURANCE COVERAGE WAIVER

I understand that my eligibility for coverage by the insurance named in the MEDICAL INSURANCE INFORMATION section of this document may not be confirmed at this time. I wish to receive medical services from CapitalCare Medical Group. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

ASSIGNMENT OF INSURANCE BENEFITS / RELEASE OF MEDICAL INFORMATION

I hereby assign to CapitalCare Medical Group (CCMG) any insurance or other third-party benefits available for health care services provided to me. If these benefits are not assigned to CCMG, I agree to forward to CCMG all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt of such payments.

I authorize CapitalCare Medical Group (CCMG) to release the minimum necessary medical or other information to persons employed or retained by or affiliated with CCMG for purposes of my diagnosis and treatment or that may be required in order to process insurance payment. I agree that these provisions will remain in effect until I provide written notice to CCMG that this authorization has been changed or discontinued.

Signature of Patient / Guardian

_____/_____/_____
Date