2010 PATIENT REGISTRATION - AACPP (Rev 4/1/2010)

Patient Name:___________________________________ Acct#: __________ Date: ___________

Birthdate: _____ Social Security Number: ____________ Sex: Male / Female School: _________

*Phone numbers: Ce **ll** ____________ Home:________________ Email:______________________*

Contact method for appointments, messages, etc (circle one): Text message Cell phone Home phone Email

Person (people) Child lives with: Mother / Father / Grandparent / Foster parent / Guardian / Other_____

Address: ____

Sibling Names/Birthdates: ____ (Use back for more)

CONTACT INFORMATION

Mother:_____________________________ Social Security Number:________ Birthdate: _______

Address: ____

Phone number: Cell: _________________ Home: _____________________ Email: __________

Father: _____________________________ Social Security Number: ________ Birthdate:_______

Address: ____

Phone number: Cell: _________________ Home: _____________________ Email: __________

Guardian/Foster parent: _______________ Social Security Number:________ Birthdate:_______

Address: ____

Phone number: Cell: _________________ Home: _____________________ Email: __________

INSURANCE INFORMATION

Primary Insurance *Copay $: ________*

Insurance company: _________________ Policy #: ____________________ Group #: ________

Policy holder name: ____________________________ SSN: ___________ Birthdate: _______

Employer: ______________ Employer phone #: ______ Insurance Phone#: _________________

Secondary Insurance *Copay $: ________*

Insurance company: _________________ Policy #: ____________________ Group #: ________

Policy holder name: ____________________________ SSN: ___________ Birthdate: _______

Employer: ______________ Employer phone #: ______ Insurance Phone#: _________________

ACCESS (PA Medicaid) Number: ____

We will need to see and copy your child's insurance card at every visit.

MEDICAL INFORMATION ABOUT PATIEN Allergies: ___________________________________

Birthplace (State or Country):____________ Language: ___________________ Race: __________

AUTHORIZATION:

• ____ Phone #_________________________ (a person other than those named above) may bring my child for care at AACPP in my absence.

- *I authorize any treatment needed for the proper care of my child by All About Children Pediatric Partners, PC.*

- *I authorize payment by my insurance company directly to AACPP of any medical/surgical benefits for the services rendered.*
- *I understand that I am financially responsible to AACPP for all payments due which are not covered by the applicable insurance plan(s).*
- *I authorize the release of any information acquired in the course of my examination or treatment to all of my covering insurance companies to process my claims and/or to a legitimate medical professional if such referral is necessary.*

Signature: *____ Date: __________*