# PATIENT REGISTRATION

Rev. 6/29/16

ACCOUNT #:_____ DATE COMPLETED:_____

***Patient Name:*** _____ ***M / F*** *Birthdate:*_____

SSN:_____

*Current School/Childcare and Current Grade:* _____

***Race*** *(Please circle all that apply): White (Caucasian), Black (African), Asian, Middle Eastern, Native American, Polynesian,* ***Hispanic:*** *Central American, Cuban, Mexican, Puerto Rican, South American. Other:*

**PARENT INFORMATION**

***Mother Name:*** _____ *Birthdate:*_____

*Address:* _____

*Home Phone:*_____ *Cell Phone:*_____ *Work Phone:*_____

*SSN:*_____ *Email:*_____

***Father Name:*** _____ *Birthdate:*_____

*Address:*_____

*Home Phone:*_____ *Cell Phone:*_____ *Work Phone:* _____

*SSN:*_____ *Email:*_____

**INSURANCE INFORMATION**

***Primary Insurance Company***_____

*Policy Holder Name:*_____ *Birthdate:* _____

*Policy Number:*_____ *Group Number*.:_____

***Secondary Insurance Company:***_____

*Policy Holder Name:*_____ *Birthdate:*_____

*Policy Number:*_____ *Group Number*.:_____

***ACCESS*** *(PA Medicaid Number):* _____

***Dentist Name:***_____ *Phone:* _____

*Last Appointment*: _____

***Emergency Contact:***

Name: _____ Phone:

*Address:* _____ *Apt. No* _____

*City:* _____ *State:* _____ *Zip:*

**Please provide us with specific information and/or legal documentation as to**

**a) who can schedule/cancel appointments** **b) person with whom we are allowed to speak regarding this patient**

**c) who may bring this child** **d) any other relevant custody information:**

*Name / Phone #/ Relationship:*_____

*Name / Phone #/ Relationship:*_____

***Please bring your child's insurance card, immunization records, and all their medicines to every visit at AACPP.***

***(Please use the back of this page to provide additional information)***

- *I authorize treatment needed for the proper care of my child by the staff at AACPP, PC to be given with my verbal consent.*
- *I authorize payment by my insurance company directly to AACPP of the medical/surgical benefits, if any, for the services rendered*
- *I understand that I am financially responsible to AACPP for all payments due which are not covered by my insurance plan*
- *I authorize the release of medical information to my health insurance to process claims and to medical professionals for consults.*

***Signature:***_____ ***Printed Name***_____ ***Date***_____

## Appointment Policy

AACPP requires 24 hours notice when an appointment must be cancelled. Same day cancellations may count as missed appointments. Three (3) missed appointments in a 12 month period may result in dismissal of all patients in the family. For patients just registering with AACPP, the first New Patient well visit must be kept in order for the family to remain with our practice.

By signing below, I accept the responsibility to follow the missed appointment policy above and understand that if I do not follow the policy, I will be considered for termination from the practice.

***Signature:***_____ ***Printed Name***_____ ***Date***_____