Child/Dependent Registration Form

Account No.	Entered Date
Reg. By	Office Site
☐ New ☐ Change	Info. Change:

Please complete this form in order to ensure proper billing of your services. **Please Print.** Today's Date: ___________

Patient Information

Patient Last Name: ___________

First Name: ___________ MI: ___________

Other Name/AKA: ___________

Addr1: ___________

Addr2: ___________

City, State, Zip: ___________

Preferred Method of Contact:
☐ Alt Phone Number ☐ Email ☐ Letter
☐ Phone Call (Cell) ☐ Phone Call (Home)

Employment Status:
☐ Employed Full Time ☐ Employed Part Time ☐ Student

Employer: ___________

Social Security Number: ___________

Date of Birth: ___________ Sex: ☐ M ☐ F

Home Phone: (______) ___________

Alt Phone: (______) ___________

Cell Phone: ___________

Email Address: ___________

Ethnicity: **(Data is used for statistical reporting.)**
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient Declined

Race: **(Data is used for statistical reporting.)**
☐ American Indian or Alaska Native ☐ Black or African American
☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ White
☐ Patient Declined

Language: ☐ English ☐ Spanish ☐ Other ___________

Insurance Information

(A separate form is required for worker's compensation, automobile liability, or legal services.)

PRIMARY CARRIER: ___________

Address: ___________

Subscriber's Name: ___________

Subscriber's DOB: ___________ Sex: ☐ M ☐ F

Subscriber's Employer: ___________

Telephone #: (______) ___________

Child's ID: ___________

Group/Plan #: ___________ Effective Date: ___________

Subscriber SS#: ___________ Relationship to Patient: ___________

PCP listed on Card: ___________

SECONDARY CARRIER: ___________

Address: ___________

Subscriber's Name: ___________

Subscriber's DOB: ___________ Sex: ☐ M ☐ F

Subscriber's Employer: ___________

Telephone #: (______) ___________

Child's ID: ___________

Group/Plan #: ___________ Effective Date: ___________

Subscriber SS#: ___________ Relationship to Patient: ___________

PCP listed on Card: ___________

Primary Care Phys.: ___________

Address: ___________

City, St., Zip: ___________

Telephone #: (______) ___________

Refer. Phys. (if different): ___________

Address: ___________

City, St., Zip: ___________

Telephone #: (______) ___________

Pharmacy Name, Address & Phone #: ___________

____

Guarantor Information

(Guarantor is the person financially responsible for this patient's bill.)

Guarantor: ______________________

Addr1: ______________________

Addr2: ______________________

City, State, Zip: ______________________

Employer: ______________________

Address: ______________________

City, State, Zip: ______________________

Driver's License # ______________ State ______

Patient's Relationship to Guarantor: ______________________

Social Security Number: ______________________

Date of Birth: ______________ Sex: ☐ M ☐ F

Home Phone: (______) ______________________

Work Phone: (______) ______________________

Cell Phone: (______) ______________________

Email Address: ______________________

Other Parent or Guardian

Parent/Guardian: ______________________

Addr1: ______________________

Addr2: ______________________

City, State, Zip: ______________________

Employer: ______________________

Address: ______________________

Work Phone: (______) ______________________

Patient's Relationship to Guarantor: ______________________

Social Security Number: ______________________

Date of Birth: ______________ Sex: ☐ M ☐ F

Home Phone: (______) ______________________

Cell Phone: (______) ______________________

City, State, Zip: ______________________

Driver's License # ______________ State ______

Emergency Contact Information

(Someone living outside the primary household.)

Last Name, First Name: ______________________

Addr1: ______________________

Addr2: ______________________

City, State, Zip: ______________________

Patient's Relationship to Contact: ______________________

Home Phone: (______) ______________________

Work Phone: (______) ______________________

Cell Phone: (______) ______________________

List All Children/Siblings

Child #1 Last Name	First Name	Date of Birth
Child #2 Last Name	First Name	Date of Birth
Child #3 Last Name	First Name	Date of Birth
Child #4 Last Name	First Name	Date of Birth

How did you hear about our practice? ☐ Billboard ☐ Brochure ☐ Health Fair ☐ Health Plan ☐ Internet ☐ Mass Mailing ☐ Newspaper/Magazine ☐ Ongoing Care ☐ Patient ☐ Phone Book ☐ Phys. Off/ER ☐ Relative ☐ Radio ☐ TV ☐ Word of Mouth ☐ Other

advocare

IDX Account #:

Assignment of Benefits / Authorization / Notice of Collection Action

I understand that I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I further understand that all co-payments are due at time of service and I am also responsible to pay other amounts due; these amounts may include annual deductibles, charges denied by my insurance company as not covered or not medically necessary, and/or any fees incurred should my account require collection action. (E.G. late fees, collection agency, court or attorney costs). Also, please be advised our office may contact you via an automated system regarding appointments and/or account status. I agree this authorization shall remain valid unless/until I rescind in writing. (Please see the Advocare Payment Policy and Notice of Privacy Practices for more information.)

Use of Photograph

The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's record and may be used by the patient's health care provider solely for the purposes of patient identification.

Vaccine Registry (if applicable)

Please be advised that our office submits confidential data of children and adult vaccinations to your States Immunization Registry per the Statewide Immunization Registry Act. The purpose of this program is to keep a central record or patient's immunization history.

Signature Required

The undersigned acknowledges that I have read and understand the above terms and conditions.

Patient Name **(Please Print)** ________________________ Patient Signature ________________________

Guarantor/Parent/Guardian completing this form **(Please Print)** ________________________ Date ____________

Guarantor/Parent/Guardian Signature ________________________ Date ____________

Please complete this section if the patient is covered by Medicare

In order to comply with Medicare regulations, please answer the following questions:

Question			Question		
Are you or your spouse employed?	☐ Y	☐ N	Has treatment been authorized by the V.A.?	☐ Y	☐ N
Do you or your spouse have other insurance?	☐ Y	☐ N	Are you covered under the Black Lung Program?	☐ Y	☐ N
Are you disabled or have end stage renal disease?	☐ Y	☐ N	Is there Medigap coverage secondary to Medicare?	☐ Y	☐ N
Is illness/injury the result of an auto accident?	☐ Y	☐ N	Is there insurance coverage primary to Medicare?	☐ Y	☐ N
Did illness/injury occur at work?	☐ Y	☐ N	Is there employer supplemental coverage secondary to Medicare?	☐ Y	☐ N

The undersigned certifies that the questions have been answered truthfully and hereby authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

Patient Name **(Please Print)** ________________________ Patient Signature ________________________

Guarantor/Parent/Guardian completing this form **(Please Print)** ________________________ Date ____________

Guarantor/Parent/Guardian Signature ________________________ Date ____________