8.2-MTBC-F-07

CONFIDENTIAL

Child Health Associates

REGISTRATION INFORMATION

PLEASE PRINT

☐ New Patient

☐ Existing Patient

Existing Patients : Onlyenter information that has changed since your last visit

EMAIL : _____

DATE :_____ / _____ / _____ HOME PHONE (_____)_____

PATIENT # 1 : _____ _____ _____
LAST FIRST MI

SOCIAL SECURITY : _____-_____-_____ SEX☐M☐F DOB : _____/_____/_____

PATIENT # 2 :_____ _____ _____
LAST FIRST MI

SOCIAL SECURITY : _____-_____-_____ SEX☐M☐F DOB : _____/_____/_____

PATIENT # 3 :_____ _____ _____
LAST FIRST MI

SOCIAL SECURITY : _____-_____-_____ SEX☐M☐F DOB : _____/_____/_____

STREET ADDRESS:_____

CITY :_____ STATE _____ ZIP : _____

MOTHER'S NAME : _____ _____ _____
LAST FIRST

Mother's Address : _____ Home Phone _____

Business Address:_____ Business Phone :_____

Date of Birth :_____ Social Security No : _____

FATHER'S NAME : _____ _____ _____
LAST FIRST

Father's Address : _____ Home (or) Contact Phone _____

Business Address: _____ Business (or) Contact Phone _____

Date of Birth :_____ Social Security No :_____

NAME OF PRIMARY INSURANCE COMPANY : _____ ID #: _____ Group#_____

Address :_____

*Subscriber :_____ *Date of Birth: _____

NAME OF SECONDARY INSURANCE COMPANY:_____ ID #:_____ Group#_____

Address :_____

*Subscriber :_____*Date of Birth: _____

*Required by HIPAA

ASSIGMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents I further expressly agree and acknowledge that my sinature on this document authorizes my physician to submit claims for benefits,for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as through the undersigned and personally signd the particular claim.

I _____ hereby authorize_____

to pay and hereby assign directly to _____ all benefits, if any, otherwise payable to me for his here srvices as described on the attached forms. I understand I am financially responsible for charges incurred.I further acknowledge that any insurance benefits, when received by and paid to _____will be credited to my account, in accordance with the above said assignment.

X _____ _____

(AUTHORISED SIGNATURE OF SUBSCRIBER) (Date)