

# 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