# Patient Registration Form

**Today's Date:** ______________________________

| Parent/Guarantor (Parent Responsible for Payment) | Other Parent |
| --- | --- |
| Full Legal Name ____________________________ | ___________________________________ |
| Male or Female (circle one) | Male or Female (circle one) |
| Birthdate __________________________________ | ___________________________________ |
| Address ___________________________________ | ___________________________________ |
| City, State, Zip _____________________________ | ___________________________________ |
| Cell Phone (    ) ____________________________ | (    ) ______________________________ |
| Home Phone (    ) ___________________________ | (    ) ______________________________ |
| Work Phone (    ) ___________________________ | (    ) ______________________________ |
| E-mail ____________________________________ | ___________________________________ |
| Employer/Occupation ________________________ | ___________________________________ |

| **<u>Primary Health Insurance Name:</u>** | Effective Date of Insurance Coverage: |
| --- | --- |
| Policy #: | Group #: |
| Policy Holder's Name: | Policy Holder's Date of Birth: |
| Mailing Address for Claims: | Phone: |
| **<u>Secondary Health Insurance Name:</u>** | Effective Date of Insurance Coverage: |
| Policy #: | Group #: |
| Policy Holder's Name: | Policy Holder's Date of Birth: |
| Mailing Address for Claims: | Phone |

Emergency Contact _________________________ Relationship _________________________________

Emergency Contact Phone (    ) _________________ Cell (    ) _________________________________

Whom may we thank for referring you to our office? _______________________________________________

**Patient Information:** **PLEASE LIST ALL CHILDREN IN THE FAMILY**

| Last | First | Middle | Birthdate | Gender |
| --- | --- | --- | --- | --- |

1.____________________________________________________________________________________

2.____________________________________________________________________________________

3.____________________________________________________________________________________

4.____________________________________________________________________________________

# Patient Registration Form

Chevy Chase
PEDIATRICS

I, the undersigned authorize payment of medical benefits to Chevy Chase Pediatric Center (CCPC) for any services furnished to me by the physician and staff of CCPC. I understand that I am financially responsible for any amount not covered by my insurance. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment, or supplies provided.

______________________________________________ ______________________________

Patient, Parent, or Guardian Signature (minor child) Date