

PATIENT REGISTRATION

ELLCOTT CITY PEDIATRIC ASSOCIATES

Reviewed by _____ ECPA

PATIENT INFORMATION

FIRST NAME		LAST NAME		M.I.
DATE OF BIRTH	PATIENT RESIDES WITH ☐ BOTH PARENTS ☐ MOM ☐ DAD ☐ LEGAL GUARDIANS ☐ STEP PARENT (name):			SEX ☐ F / ☐ M
ADDRESS		APT	CITY	ZIP
PATIENT'S CELL (if over age of 17) _____ - _____ - _____		RACE	ETHNICITY	
PREFERRED LANGUAGE :		☐ ASIAN ☐ AFRICAN AMERICAN OR BLACK ☐ HAWAIIAN OR PAC.ISLANDER ☐ CAUCASIAN OR WHITE ☐ NATIVE AMERICAN OR ALASKAN ☐ DECLINED TO ANSWER	☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ UNKNOWN ☐ DECLINED TO ANSWER	

1. PARENT / GUARDIAN INFORMATION *(if Legal Guardian, please provide us with paperwork)*

FIRST NAME	LAST NAME		DATE OF BIRTH
ADDRESS (IF DIFFERENT FROM PATIENT'S)		APT	CITY ZIP
EMAIL (it will be your Patient Portal ID)	HOME PHONE: _____ - _____ - _____ CELL PHONE : _____ - _____ - _____ WORK PHONE: _____ - _____ - _____		RELATIONSHIP TO PATIENT :
SOCIAL SECURITY NUMBER	EMPLOYER		OCCUPATION

2. PARENT / GUARDIAN INFORMATION *(if Legal Guardian, please provide us with paperwork)*

FIRST NAME	LAST NAME		DATE OF BIRTH
ADDRESS (IF DIFFERENT FROM PATIENT'S)		APT	CITY ZIP
EMAIL (it will be your Patient Portal ID)	HOME PHONE: _____ - _____ - _____ CELL PHONE : _____ - _____ - _____ WORK PHONE: _____ - _____ - _____		RELATIONSHIP TO PATIENT :
SOCIAL SECURITY NUMBER	EMPLOYER		OCCUPATION

PREFERRED CONTACT REGARDING APPOINTMENT REMINDERS (CHECK ONE)

☐ TEXT TO CELL	☐ CALL HOME NUMBER	☐ EMAIL	☐ NO CONTACT
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INSURANCE INFORMATION *(Medical Assistance MUST be Secondary if you carry Commercial Insurance)*

FINANCIALLY RESPONSIBLE PERSON (CHECK ONE)

☐

PATIENT

☐

MOTHER

☐

FATHER

☐

OTHER

POLICY HOLDER'S NAME:

DOB

SEX:

☐

M

/

☐

F

POLICY HOLDER'S ADDRESS *(IF DIFFERENT FROM PATIENT'S)*

INSURANCE NAME:

ID :

GROUP:

EFFECTIVE DATE:

S.S.N. :

EMPLOYER:

POLICY HOLDER'S PHONE

SECONDARY INSURANCE

FINANCIALLY RESPONSIBLE PERSON (CIRCLE ONE)

☐

PATIENT

☐

MOTHER

☐

FATHER

☐

OTHER

POLICY HOLDER'S NAME:

DOB

SEX:

☐

M

/

☐

F

POLICY HOLDER'S ADDRESS *(IF DIFFERENT FROM PATIENT'S)*

INSURANCE NAME:

ID :

GROUP:

EFFECTIVE DATE

S.S.N. :

EMPLOYER:

POLICY HOLDER'S PHONE

AUTHORIZATION

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Ellicott City Pediatric Associates (ECPA) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize ECPA to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I further agree to pay any collections and/or legal fees necessary for collection, if such situation was to arise.

Signature of Subscriber or Beneficiary_____
Date**SIBLINGS**

NAME	DOB	☐ F / ☐ M
NAME	DOB	☐ F / ☐ M
NAME	DOB	☐ F / ☐ M
NAME	DOB	☐ F / ☐ M

EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE#
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