

Mountain View Pediatrics – Patient Registration Forms (Page 2 of 2)

Insurance Information

(Must be completed in full so that we may submit to your insurance for reimbursement)

Insurance cards must be presented at every visit

Primary Insurance Name: _____ **ID#** _____ **Group#** _____

Policyholder's Information:

Name: _____ **Date of Birth:** _____ **Social Security #** _____

Sex: Male Female **Employer:** _____ **Relationship:** Child Other/dependent

Effective Date: _____

Secondary Insurance Name: _____ **ID#** _____ **Group#** _____

Policyholder's Information:

Name: _____ **Date of Birth:** _____ **Social Security #** _____

Sex: Male Female **Employer:** _____ **Relationship:** Child Other/dependent

Effective Date: _____

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Mountain View Pediatrics **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

Further, I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicaid), for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE AT THE PROVIDERS' CURRENT RATE MAY BE CHARGED on all balances owed to the provider that are past due.

Signature: _____ **Date:** _____

Emergency Contact:

Name: _____ **Phone#** _____ **Relationship:** _____

Address: _____ **City** _____ **State** _____ **Zip Code:** _____

Patient's Preferred Method(s) of Contact:

- Home Telephone Written Communication
 Cell Telephone Email Communication