CHILD AND ADOLESCENT CLINIC
REGISTRATION FORM

Please include all children who have the same parents and live in the same household on one registration sheet.

Child's Name ____**Birthdate** ________________
Sex: Male / Female **Primary Language**: English / Other: ______________________
Race: White / Asian / Black / American Indian / Alaskan Native / Hawaiian Native / Pacific Islander
Cultural Background: Hispanic / Non-Hispanic **School** ____________________________

Child's Name ____**Birthdate** ________________
Sex: Male / Female **Primary Language**: English / Other: ______________________
Race: White / Asian / Black / American Indian / Alaskan Native / Hawaiian Native / Pacific Islander
Cultural Background: Hispanic / Non-Hispanic **School** ____________________________

Child's Name ____**Birthdate** ________________
Sex: Male / Female **Primary Language**: English / Other: ______________________
Race: White / Asian / Black / American Indian / Alaskan Native / Hawaiian Native / Pacific Islander
Cultural Background: Hispanic / Non-Hispanic **School** ____________________________

Child's Name ____**Birthdate** ________________
Sex: Male / Female **Primary Language**: English / Other: ______________________
Race: White / Asian / Black / American Indian / Alaskan Native / Hawaiian Native / Pacific Islander
Cultural Background: Hispanic / Non-Hispanic **School** ____________________________

Address of Child's Home: ____
ADDRESS CITY/STATE ZIP

Phone (_____)_____________________________ **Circle one:** land line / cell

Parent/Guardian 1___________________________________ **Relation to Patient** ________________

Lives with patient? Yes / No **Birthdate** ________________ **Social Security #** ________________

Employer ___________________________________ **Phone #** _____________________**Ext.**________

Cell Phone # _________________________ **Email address** _______________________________

How would you like appointment reminders? Email _____ Text to Cell _____ Phone call _____
Yes / No Would you like secure access to your child's medical record through our Patient Portal?

Parent/Guardian 2___________________________________ **Relation to Patient** ________________

Lives with patient? Yes / No **Birthdate** ________________ **Social Security #** ________________

Employer ___________________________________ **Phone #** _____________________**Ext.**________

Cell Phone # _____________________ **Email address** _______________________________

How would you like appointment reminders? Email _____ Text to Cell _____ Phone call _____
Yes / No Would you like secure access to your child's medical record through our Patient Portal?

EMERGENCY CONTACT: Friend or relative **<u>not living with you</u>** to contact in case of an emergency:

Name _____________________________ Phone # ________________ Relationship _____________

PLEASE CONTINUE TO REVERSE SIDE FOR INSURANCE AND PRIVACY PRACTICES INFORMATION

Updated ______
Scanned ______

CHILD AND ADOLESCENT CLINIC
REGISTRATION FORM

INSURANCE INFORMATION

Primary Insurance Company _____ Group # _____

Subscriber's Name _____ ID # _____

Employer's Name _____

Secondary Insurance Company _____ Group # _____

Subscriber's Name _____ ID # _____

Employer's Name _____

PRIVACY PRACTICES

I acknowledge that Physician's Notice of Privacy Practices has been offered to me. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved the right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available to me.

Signature _____

Relationship to Patient _____ Date _____

FINANCIAL RESPONSIBILITY

I understand that I am responsible for all fees, regardless of insurance coverage. Payment is required at the time or service unless other arrangements have been made in advance with the billing department. Child and Adolescent Clinic submits claims to a number of carriers. I will check with the receptionist to see if my plan is one of them. All other insurance claims are the responsibility of the family.

Co-payments and deductibles must be paid at the time of service. There is a fee charged for co-payments not made at the time of service. Any charges not paid by my insurance company within 45 days of the date of service will become the responsibility of the family.

I have read the above policy. I hereby assign to the physician all payments for medical services rendered. I understand that I am responsible for any amount not covered by my insurance.

Signature: _____ Date: _____

How did you hear about our clinic? (check all that apply)

□ Friend □ Family □ Coworker □ Newspaper □ Web search □ Phone book
□ I/we came to CAC as a child

Updated _____
Scanned _____