Patient Registration

Cape Cod Pediatrics
Boston Children's
Primary Care Alliance

capecodpediatrics.com
508-477-5306 | *fax* 508-477-0297

Patient information (please print)

Last name: _____

First name: _____ Middle initial: _____

Date of birth: _____ Gender: ❍ Male ❍ Female

Home address: _____

City: _____ State: _____ Zip code: _____

Mailing Address (If difference than home): _____

City: _____ State: _____ Zip code: _____

Home phone: _____

Patient's Cell (If 13 and older): _____

Patient's Email (If 13 and older) (Non-School): _____

Patient's Preferred Spoken Language (Leave blank for patients under 5 years old): _____

Family information

Parent/Guardian 1

Last name: _____

First name: _____ Middle initial: _____

Relationship to patient: _____ Date of birth: _____

Phone: _____ Cell phone: _____
Other: _____

SSN: _____Dl#: _____ State: _____

Email: _____

Parent/Guardian 2

Last name: _____

First name: _____ Middle initial: _____

Relationship to patient: _____ Date of birth: _____

Phone: _____ Cell phone: _____
Other: _____

SSN: _____Dl#: _____ State: _____

Email: _____

NOTE: Legal documentation is required if legal guardian is other than a Parent

Emergency Contact: _____
Relationship: _____
Phone: _____ Cell phone: _____
Other: _____

Insurance information

Primary Insurance: _____

ID #: _____ Group #: _____

Subscriber Name: _____

Date of birth: _____

Secondary Insurance: (If Applicable): _____

ID #: _____ Group #: _____

Subscriber Name: _____

Date of birth: _____

Assignment of Benefits and Release of Information

I hereby authorize Cape Cod Pediatrics, LLP (CCP) to release any information necessary to process my insurance claim. I agree to furnish CCP with a copy of my current health insurance card(s). I authorize and direct my insurance carrier to issue payment directly to CCP. Regardless of my insurance benefits, if any, I understand that I am fully financially responsible for any fees incurred. I agree to pay such fees in full. I agree that it is my responsibility to provide CCP with my current insurance information, and in not doing so within the time limitations set by my insurance company for claim submission, I understand that I will be fully financially responsible for those charges.

I authorize treatment to be given by the Providers of CCP, and covering Providers, to my child when accompanied by myself or by an authorized caregiver. Failure to remit payment within 90 days may jeopardize patient status.

Notice of Privacy Practices Acknowledgement and Consent

By signing below, I acknowledge that I have received/read a copy of CCP's HIPAA Privacy Practices and therefore have been advised how health information about my child may be used and disclosed by them, and how I may obtain access to and control of this information.

Notice of Medication History Authorization

CCP is required to obtain my consent in order to access a list of my child(ren's) past prescription medication from my pharmacy, health plans, or my other healthcare Providers. By signing below, I agree to this consent and understand it will not terminate or expire unless I deliver notice of such termination to the practice.

Parent/Guardian Signature: _____

Print Name: _____

Date: _____

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