CENTER FOR pediatric and adolescent MEDICINE, PA

CPAM CHART # _____

WE IMMUNIZE
FOLLOWING THE 2009 CDC CHILDHOOD AND ADOLESCENT IMMUNIZATION SCHEDULE

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PATIENT REGISTRATION & ACKNOWLEDGEMENT OF INSURANCE/BILLING

PATIENT

Last Name, First Name, Middle Name of Patient *(Please Print or Type)*		Patient Name Called
☐ MALE ☐ FEMALE		
Street Address or Post Office Box		Patient Date of Birth
City, State, Zip Code		Patient Social Security #
Patient Lives With: *(Please Check)*	Home Phone # *(OK to Leave Message?)*	Cell Phone or Alternate #
☐ BOTH PARENTS ☐ MOM ☐ GUARDIAN ☐ GRANDPARENT(S) ☐ DAD ☐ OTHER	☐ YES ☐ NO	

BILLING CONTACTS

Last Name, First Name, Middle Initial of Person Responsible for Payment of Services	Home/Cell Phone # *(If Different)*
☐ DAD ☐ MOM ☐ OTHER	
Street Address or Post Office Box *(If Different)*	Place of Employment
City, State, Zip Code	Work Phone #
First, Middle Initial, Last Name of Other Parent/Guardian	Other Parent's Place of Employment
☐ DAD ☐ MOM ☐ OTHER	

INSURANCE

Last Name, First Name, Middle Initial of Insurance Policy Holder - *(Subscriber)*		Policy Holder's Social Security #
☐ MALE ☐ FEMALE		
Primary Insurance Company *(Copy of Current Insurance Card Required)*	Co-Pay	Policy Holder's Date of Birth
	$	
Policy ID #	Group ID #	Effective Date of Current Policy

By signing/acknowledging this document, I hereby authorize and/or understand (a) payment of insurance benefits otherwise due to me to be made directly to the Center for Pediatric and Adolescent Medicine, (b) the release of information to insurance companies as needed to file for payment for services incurred, (c) the Center for Pediatric and Adolescent Medicine to obtain records from other sources as may be necessary in the diagnosis or treatment of the stated patient, and (d) I am financially responsible for payment to the Center for Pediatric and Adolescent Medicine for charges related to services provided to or incurred by me or my dependents including but not limited to co-pay and co-insurance amounts, deductible amounts, charges for treatments not covered by insurance, and/or insurance filed with inaccurate/terminated coverage information, (e) the Center for Pediatric and Adolescent Medicine will bill me directly any balances for office visits, services and/or procedures should the insurance company I provided to them not respond to the filing of the medical claim within 90 days of the date of service, and (f) to the best of my knowledge, the information presented by me is accurate and correct.

REQUIRED SIGNATURE

2009

_____
Signature of Patient or Patient Representative Date

_____
Print Name of Patient Representative and Relationship to Patient

_____
E-Mail Address *(E-mail Correspondence Form)* ☐Yes ☐No

****** PLEASE NOTE ******
TO BE REGISTERED AS A PATIENT, ALL INFORMATION ABOVE MUST BE FILLED OUT COMPLETELY

MD Request: ☐Tilt ☐Little ☐Abbott ☐Thomas

How did you find out about our practice? ☐Friend ☐Professional Referral ☐Web Site ☐Advertisement ☐Other: _____ *(Please State)*