PATIENT REGISTRATION

ELLICOTT CITY PEDIATRIC ASSOCIATES

Reviewed by _____ECPA

PATIENT INFORMATION

FIRST NAME	LAST NAME	M.I.

DATE OF BIRTH	PATIENT RESIDES WITH	SEX
	☐ BOTH PARENTS ☐ MOM ☐ DAD ☐ LEGAL GUARDIANS ☐ STEP PARENT (name):	F / M

ADDRESS	APT	CITY	ZIP

PATIENT'S CELL (if over age of 17)

_____-_____-_____

PREFERRED LANGUAGE :

RACE

- ☐ ASIAN
- ☐ AFRICAN AMERICAN OR BLACK
- ☐ HAWAIIAN OR PAC.ISLANDER
- ☐ CAUCASIAN OR WHITE
- ☐ NATIVE AMERICAN OR ALASKAN
- ☐ DECLINED TO ANSWER

ETHNICITY

- ☐ 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)*		RELATIONSHIP TO PATIENT :
	HOME PHONE: _____-_____-_____ CELL PHONE : _____-_____-_____ WORK PHONE: _____-_____-_____	

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)*		RELATIONSHIP TO PATIENT :
	HOME PHONE: _____-_____-_____ CELL PHONE : _____-_____-_____ WORK PHONE: _____-_____-_____	

SOCIAL SECURITY NUMBER	EMPLOYER	OCCUPATION

PREFERRED CONTACT REGARDING APPOINTMENT REMINDERS (CIRCLE ONE)

TEXT TO CELL	CALL HOME NUMBER	EMAIL	NO CONTACT

INSURANCE INFORMATION *(Medical Assistance MUST be Secondary if you carry Commercial 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				

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#**