Patient Registration Form

Patient's name: ______________________________ Date of Birth: ____________ Male/Female/Other

Street Address: ______________________________ City, State: _____________ Zip code: _________

1st phone #:____________________ **2nd phone #:____________________** **3rd phone #:____________________**

Mom/Dad/Other: __________ **Mom/Dad/Other: __________** **Mom/Dad/Other: __________**

(Will be first called for all contact)

Messages about labs may be left on this phone#: ______________________________

Appointment Reminder Preference: (please select ONLY one)

Phone call: ____________________ Email: ______________________________

*Text Message: ____________________ ***Send new text msg to ph# 622622 with the message CPA to Opt In.**

Parent/Guardian Name: ______________________________ Date of Birth: _______________

Occupation: ______________________________ Employer: ______________________________

Email Address: ______________________________

Parent/Guardian Name: ______________________________ Date of Birth: _______________

Occupation: ______________________________ Employer: ______________________________

Email Address: ______________________________

Emergency Contact #1 (other than child's parents): ______________________________

1st phone #: ____________________ **2nd phone #: ____________________**

Emergency Contact #2 (other than child's parents): ______________________________

1st phone #: ____________________ **2nd phone #: ____________________**

Insurance Information (Fill out unless you gave a card TODAY.)

Primary Insurance Company: ______________________________ Effective Date: ____________________

Claim Address: ______________________________ Telephone#: _______________

ID#: ____________________ Group#: ____________________ Copay: ____________________

Name of Insured: ______________________________Relationship to Patient: ____________________

Billing Information (If different than Parent/Guardian information)

Name of Individual: ______________________________ Relationship to Child: ____________________

Street Address: ______________________________ City, State & Zip:____________________

Mobile#: ____________________ Home#: ____________________

Assignment of Insurance Benefits & Authorization to Release Information

I hereby authorize payment of healthcare benefits to **Clinical Pediatric Associates of North Texas** for the services rendered by any person under the physician's supervision. I understand that I am financially responsible for any balance not covered by my insurance carrier. I also authorize **Clinical Pediatric Associates of North Texas** to release any medical information or incidental information that may be necessary for either medical care, processing applications for financial benefit and health care operations including my insured dependent(s) over 18 years of age.

Patient's Name: ____

Parent/Guardian Name: ____

Parent/Guardian Signature: ____

Date Signed: ___________________________________

This information is requested for statistical reasons only.

Please Circle one:		**Please Circle one:**		
Race:	American Indian	**Ethnicity**:	Hispanic or Latino	**Preferred language**:
	Asian			
	Black or African American		Not Hispanic or Latino	______________
	Native HI/Pacific Islander			
	White		Prefer not to answer	Prefer not to answer
	Prefer not to answer			