ACADEMY PARK PEDIATRICS
REGISTRATION FORM

Date:____________________ (Expires every 12 months or if information changes)

Patient's name:______________________________Male Female Date of Birth__________________
Patient's name:______________________________Male Female Date of Birth__________________
Patient's name:______________________________Male Female Date of Birth__________________
(Please list all children in household) (circle one)

Mother's Information: Name_________________________________SS#_________________________
Address:____Date of Birth:________________
Street/Apartment or Unit# City State Zip
Phone#____________________Alternate Phone#____________________Work Phone#________________
Mother's Employer_____________________________________Position____________________________

Father's Information:Name__________________________________SS#_________________________
Address:____Date of Birth:________________
Street, Apartment or Unit# City State Zip
Phone#____________________Alternate Phone#____________________Work Phone#________________
Father's Employer_____________________________________Position____________________________

Step Parent: (if applicable)____

Financially Responsible Party:________________________________SS#______________________
Address:____Date of Birth:______________
Street, Apartment or Unit# City State Zip
Relationship to patient:____

Emergency Contact:____Phone:______________________

Primary Insurance__________________________________ID#_______________________________
Group#______________________________Policy Holder:______________________________________
Policyholder Relationship to Patient:____
Secondary Insurance________________________________ID#_______________________________
Group#______________________________Policy Holder:______________________________________
Policyholder Relationship to Patient:____

BILLING POLICY

*Copayment/Self Pay due at time of service. Non Payment may require postponement of appointment.
*Balances due may carry a $6/month rebilling charge payable by parent, guardian, responsible party.
*Well Care appointments missed or not cancelled 24 hours in advance may be charged $25 fee per child/parent responsibility.
*Patients must be PRE APPROVED for Medicaid or CHP+. If pre approval is not obtained, no past, current or future charges will be billable to Medicaid or CHP+. Medical services will need to be provided elsewhere by an open practice.
***I accept responsibility for any unpaid services or services not covered by insurance. Should it become necessary to forward my account for professional collection, in addition to the amount owed, I will also be responsible for reasonable costs of collection including attorney fees.**
See HIPAA and FINANCIAL AGREEMENT for expanded information

SIGNED:_________________________________Relationship to Patient______________________________

Signature of patient if over 18 years of age____