CAPE FEAR ORTHOPAEDIC CLINIC, PA
PEDIATRIC REGISTRATION FORM

For Office Use Only

Accident Status Y N A W B O Interviewers Initials_____

Account Type 01 02 03 04 05 06 07 0 8 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

Patient Seen by Dr #_____ Patient Problem_____ DOI/Onset_____

☐ New Patient ☐ New Problem ☐ Annual Update ☐ Ins Update ☐ Address Change ☐ Phone # Change **CHART #**_____

Patients' Legal Name_____ DOB _____/_____/_____
(Last) (First) (MI)

Patients' Sex: ___ Male ___ Female Patients' Social Security #_____ Age_____

Mailing Address_____
(Street/PO Box) (City) (State) (Zip)

Home Address_____
(Street) (City) (State) (Zip)

Patients' Home Phone_____

Mothers Name_____ SSN_____ DOB_____

Mothers Employer_____ Work Phone_____ Cell Phone_____

Employer Address_____
(Street) (City) (State) (Zip)

Fathers Name_____ SSN_____ DOB_____

Fathers Employer_____ Work Phone_____ Cell Phone_____

Employer Address_____
(Street) (City) (State) (Zip)

Referring Physician_____ City_____

Family Physician_____ City_____

1. Primary Insurance Information:

Insurance Co. Name/Address_____ Effective Date_____

Policy Holder's Name_____ Sex: __M __F DOB_____

Policy Holder's SSN_____ Pt's Relationship to Policy Holder_____

Policy ID #_____ Group #_____

2. Secondary Insurance Information:

Insurance Co. Name/Address_____ Effective Date_____

Policy Holder's Name_____ Sex: __M __F DOB_____

Policy Holder's SSN_____ Pt's Relationship to Policy Holder_____

Policy ID #_____ Group #_____

In Case of an emergency, name the nearest local relative or friend (Not living with you):

Name_____ Phone #_____

I hereby certify that the information provided above is complete and correct. I authorize Cape Fear Orthopaedic Clinic, P.A. to submit claims and assign benefits, on my behalf, to my insurance company. I agree to be financially responsible for all services and materials not paid by my insurance benefit plan, unless the treating physician has a contractual agreement with my insurance plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any health information relating to this claim.

_____ _____
Signed (Patient/Parent/Guardian) Date