Child's Registration Form

Child's name: ______________________________ Date of Birth: ___________ Sex: Male/Female

Street Address: ______________________________ City, State: ____________ Zip code: ________

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

Appointment reminders & messages about labs may be left on this phone#:_________________________

Please Circle one:
Race: American Indian
Asian
Black or African American
Native HI/Pacific Islander
White
Prefer not to answer

Please Circle one:
Ethnicity: Hispanic or Latino
Not Hispanic or Latino
Prefer not to answer

Preferred language:
____
Prefer not to answer

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.

Mother/Guardian Name: ______________________________ Date of Birth: _____________

Occupation: ______________________ Employer: ______________________

Email Address: ____

Father/Guardian Name: ______________________________ Date of Birth: _____________

Occupation: ______________________ Employer: ______________________

Email Address: ____

Child's Siblings

Name: ______________________________________ Date of Birth: _____________

Name: ______________________________________ Date of Birth: _____________

Name: ______________________________________ Date of Birth: _____________

Name: ______________________________________ Date of Birth: _____________

(OVER)

Insurance Information

Primary Insurance Company: ____ Effective Date: ___________________

Claim Address: ____ Telephone#: ______________

ID#: _____________________________ Group#: _____________________________ Copay: ___________________

Name of Insured: ____ Insured SS#: ___________________________

Relationship to Patient: ___________________________

Billing Information

Name of Individual: ____ Relationship to Child: ____________________

Street Address: ____ City, State & Zip:__________________________

Mobile#: ______________________________ Home#: ______________________________

Contacts

Referred by: __________________________ Address: ______________________________ Phone#:_____________

Closest Relative (not at your address):______________________________ Address: ________________________________

1st phone #:_______________________________________ 2nd phone #:___________________________________

Emergency (other than child's parents): _____________________________Address: _________________________________

1st phone #:_______________________________________ 2nd phone #:___________________________________

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.

Child's Name: ____

Parent/Guardian Name: ____

Parent/Guardian Signature: ____

Date Signed: ____________________________________