

# Bluegrass Pediatrics & Internal Medicine

## PATIENT REGISTRATION FORM

### PATIENT INFORMATION: (Please Print)

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_

Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ ZIP: \_\_\_\_\_

Street Address (if different from billing): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Employment Status:  Employed  Retired  Self Employed  Unemployed /  Full Time  Part TimeOccupation: \_\_\_\_\_ Student:  Full Time  Part Time

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

### PARENT/RESPONSIBLE PARTY (if different from patient)

Name: \_\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

### INSURANCE INFORMATION/POLICY HOLDER:

Do you have insurance?  Yes  No**Primary Insurance:** \_\_\_\_\_ Subscriber ID #: \_\_\_\_\_Group #: \_\_\_\_\_ *Name of Cardholder:* \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS #: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Subscriber ID #: \_\_\_\_\_Group #: \_\_\_\_\_ *Name of Cardholder:* \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS #: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship: \_\_\_\_\_

### OTHER INFORMATION:

Referred by: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Pharmacy of choice: \_\_\_\_\_ Phone: \_\_\_\_\_

Do we have your permission to:

Leave a message on your answering machine at home?  Yes  No

In case of Emergency, whom should we notify? \_\_\_\_\_

Emergency Contact Address \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

**\*\*\*\*\* TURN OVER PAGE AND SIGN FORM PLEASE\*\*\*\*\***

**Bluegrass Pediatrics & Internal Medicine**  
**PATIENT REGISTRATION FORM**

**ASSIGNMENT OF BENEFITS:**

I hereby assign all medical/surgical benefits to include major medical benefits to which I am entitled. This includes Medicare, private insurance, and other health plans to Bluegrass Pediatrics & Internal Medicine. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize the release of all of my medical records from other physicians and institutions in order that I may be given the appropriate care.

**AUTHORIZATION TO RELEASE INFORMATION:**

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Center for Medicare and Medicaid Services (CMS, formerly HCFA) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place to the original signed assignment. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (section 1128B of the Social Security Act and 31U.S.C.3801-3812 provides penalties for withholding this information.) We will file all claims as a courtesy to you and your insurance company(s) and all necessary documentation for claim processing.

**PATIENT FINANCIAL RESPONSIBILITY:**

**If your insurance company has not paid your claim after 90 days, the full amount of the bill is your responsibility and payment is due immediately. Furthermore, I understand that, if for any reason, the account is turned over to a collection agency, I will be responsible for the collection fee of 35% and should non-payment of your account result in litigation, the collection fee shall increase to 50%, and I will also be responsible for court cost and service of summons cost.**

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Patient or Responsible Party Signature

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Date Signed