Rappahannock Pediatric Associates, P.C.

Today's Date: _____

Patient Registration Form
Please Fill out form Completely

PATIENT INFORMATION

Patient Last Name	Patient First Name	MI	Sex	Date of Birth	Social Security #
Address				Home Phone #	Cellular #
City	State	Zip		E-mail	
Father's Last Name	First Name	MI	Sex	Date of Birth	Social Security #
Address				Home Phone #	Cellular #
City	State	Zip		Marital Status Single Married Divorced	
E-mail	Employer			Employer Phone #	
Mother's Last Name	First Name	MI	Sex	Date of Birth	Social Security #
Address				Home Phone #	Cellular #
City	State	Zip		Marital Status Single Married Divorced	
E-mail	Employer			Employer Phone #	

Responsible Party & Insurance Information

Responsible Party's Last Name	First Name	MI	
Address	Home Phone #	Cellular #	
Secondary Insurance Company	Policy #	Group #	
Secondary Insured's Name	Secondary Insured's SS#	Date of Birth	Relationship to Patient
Secondary Insurance Address	City	State	Zip
Primary Insurance Company	Policy #	Group #	
Primary Insured's Name	Primary Insured's SS#	Date of Birth	Relationship to Patient
Primary Insurance Address	City	State	Zip

Signature Required

Assignment of Insurance Benefits: I hereby authorize payment to this practice for any benefits payable to me for healthcare services provided to the patient at this practice. I understand that if health insurance information is provided, this in no way relieves me of financial responsibility for services rendered now or in the future at this practice.

Guarantee of Payment: I understand that I am financially responsible for all amounts payable with regards to fees for healthcare services rendered now and in the future by this practice. In the event of non payment of any amounts due by the responsible party to this practice I agree that in addition to the amount due, I am responsible to pay late fees of $25 on accounts over 60 days and collection fees of 33 and 1/3% of the amount due, court costs and reasonable attorney fees on delinquent accounts.

Signature of Responsible Party _____ Date _____