Capitol Pediatrics, P.C.
Registration Form

How did you hear about us? _____

Child's Information

Name: _____ DOB: _____ SSN: _____
Address: _____ City/State/Zip: _____
Home Phone: _____ Cell Phone: _____ Email: _____
Emergency Contact (other than parent) _____
Name Phone Relationship
Race/Ethnicity: _____ Preferred Language: _____

Sibling Information

LAST NAME	FIRST NAME	BIRTHDATE	SEX	SSN

Parent #1 Information

Name: _____ Sex: _____
Address: _____
City/State/Zip: _____
Date of Birth: _____
SSN: _____
Email: _____
Home Phone: _____
Cell Phone: _____
Employer: _____
Work Phone: _____

Parent #2 Information

Name: _____ Sex: _____
Address: _____
City/State/Zip: _____
Date of Birth: _____
SSN: _____
Email: _____
Home Phone: _____
Cell Phone: _____
Employer: _____
Work Phone: _____

** Please note that parent's social security numbers will be needed for identification purposes. All numbers are secured. **

Insurance Information

Primary Insurance: _____ Subscriber: _____
Secondary Insurance: _____ Subscriber: _____

WHO IS RESPONSIBLE FOR THE BILL? _____

I agree to notify Capitol Pediatrics, P.C. of any address, telephone, or employer changes immediately. I hereby authorize Capitol Pediatrics, P.C. to release all necessary information to the insurance company for filing claims as well as other physicians when care is being coordinated. I hereby assign payment directly to Capitol Pediatrics, P.C. of benefits otherwise payable to me. I authorize Capitol Pediatrics, P.C. to file complaints to the insurance company and the insurance commissioner on my behalf. I understand that I am required to show my current insurance card and pay any copays/coinsurance at each visit. I understand that I am financially responsible for charges not covered by insurance. I understand if my account is sent to a collection agency and/or collection attorney, I agree to pay, in addition to all other amounts I owe, any and all costs of collection including, without limitation, an attorney fee equal to one-third (1/3) of my outstanding balance and other costs associated with collection, to include any credit/debit card transaction fees, should I choose to pay by those means. I understand if any balance due is not paid in full within sixty (60) days from the date of service, I further agree to pay interest at a rate of 3% per annum. I further agree that once my delinquent account is sent to a collection agency and/or collection attorney, my debt may be collected by using enforcement actions allowable under the law such as commencing a civil action to collect the debt, docketing judgements, or placing a lien, such as a garnishment, against wages or bank accounts.

Parent's Printed Name: _____ Date: _____
Parent's Signature: _____