Boston Children's Health Physicians
Until every child is well™

BCHP REGISTRATION

DATE: _____

PATIENT NAME: _____ _____ **MED. REC. #:** _____

PATIENT ADDRESS: _____ **DATE OF BIRTH:** _____/_____/_____

_____ **AGE:** _____ **GENDER:** _____

RESPONSIBLE PARTY/GUARDIAN: _____ **RELATIONSHIP:** _____

MAILING ADDRESS: _____ **HOME PHONE:** _____

_____ **CELL PHONE:** _____

WORK PHONE: _____

PARENT/GUARANTOR #1: _____ **PHONE:** _____

ADDRESS: _____ **EMAIL:** _____

_____

EMPLOYER: _____ **EMPLOYER ADDRESS:** _____

PARENT/GUARANTOR #2: _____ **PHONE:** _____

ADDRESS: _____ **EMAIL:** _____

_____

EMPLOYER: _____ **EMPLOYER ADDRESS:** _____

EMERGENCY CONTACT NAME: _____ **RELATIONSHIP:** _____

PHONE NUMBER: _____

PRIMARY INSURANCE: _____ **ID #:** _____

INS. ADDRESS: _____ **CARDHOLDER:** _____

_____ **CARDHOLDER DOB:** _____ **SEX:** _____

INS. TELEPHONE #: _____ **EFFECTIVE DATE:**_____

SECONDARY INSURANCE: _____ **ID #:** _____

INS. ADDRESS: _____ **CARDHOLDER:** _____

_____ **CARDHOLDER DOB:** _____ **SEX:** _____

INS. TELEPHONE #: _____ **EFFECTIVE DATE:** _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize BCHP to release information concerning treatment or services rendered to Medicare/other insurance carriers responsible for my or my dependent's care. I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to BCHP for any services rendered. I have been advised that if my insurance requires a co-pay it is due at the time of the visit. Otherwise, a $15 surcharge will be added to my bill.

Signature of Patient: _____ **Date:** _____

Created by Ellen Nolan 12/30/10; edited by Lauren Coluccio 5/6/2016