WATERTOWN PEDIATRICS, PC
NORTH COUNTRY MEDICAL CENTER
1571 WASHINGTON STREET, SUITE 107
WATERTOWN, NY 13601
PHONE: 315.782.7330
FAX: 315.782.5773

PATIENT REGISTRATION FORM

Patient Name: _____ DOB:_____
FIRST MI LAST

Race (optional): American Indian/Alaskan Native Asian Black/African American Hawaiian/Pacific Islander White Other Decline/Refuse to Answer/Unknown
Ethnicity: Hispanic Non-Hispanic Primary Language: _____

☐ MALE ☐ FEMALE Patient SS#_____

Patient Address: _____

Parent/Guardian Demographics

Mother's Name_____

Address: _____

_____

DOB: _____ SS# _____

Home# _____ Cell# _____

Father's Name_____

Address: _____

_____

DOB: _____ SS# _____

Home# _____ Cell# _____

Legal Guardian Name: _____ DOB: _____ Phone# _____
(IF OTHER THAN BIOLOGICAL PARENTS)
Address: _____

Emergency Contact: _____ Phone: _____

E-Mail for portal use: _____

Insurance Information

Primary Insurance: _____ ID# _____ Effective Date:_____

Policy Holder: _____ DOB: _____ Employer: _____

Secondary Insurance: _____ ID# _____ Effective Date:_____

Policy Holder: _____ DOB: _____ Employer: _____

Guarantor if other than policy holder: _____ DOB: _____

Acknowledgement of Receipt of Privacy Practices

I, _____ have read **WATERTOWN PEDIATRICS'** Notice of privacy Practices effective April 14, 2003.

Signature: _____ Date: _____

Advanced Beneficiary Notice (ABN)

(Note: You will need to make a choice about certain health-care items and/or services.)

Your health insurance may only pay for certain item(s) or service(s) offered through our practice. The plan you have chosen as your health insurance does not necessarily cover all your health care cost. Insurance only pays for covered items and services. (Covered and non-covered items and services can be found in your health insurance contract or by contacting your health insurance plan. We do not know your health insurance plan and it is your responsibility to know whether certain items or services are or are not covered.) The fact that your health insurance plan may not pay for a particular service does not mean that you should not receive them, especially if your physician recommends that you should receive the items or services.

Signature: _____ Date: _____

Watertown Pediatrics Office Policies

- I authorize the release of any medical or necessary information to the insurance company to process any insurance claims.
- I authorize payment of medical benefits to **WATERTOWN PEDIATRCS, PC.**
- I authorize **WATERTOWN PEDIATRCS, PC** to provide medical treatment to my child.
- I authorize the release of my child's immunization records to his/her school per their request.
- I understand there will be a $25 (twenty-five dollar) service charge for any missed appointment that I do not call to cancel or reschedule. Three (3) or more missed appointments may lead to dismissal.
- I understand that a fee of up to $25 (twenty-five) dollars may be charged for the completion of any medical forms.
- I understand that a parent or guardian must always be present at the time of the appointment regardless of the patient's age.

Signature: _____ Date: _____

OFFICE USE

VERIFIED/ENTERED BY: _____