

**BCHP REGISTRATION**

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ MED REC NUMBER: \_\_\_\_\_

PATIENT ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ GENDER: \_\_\_\_\_

**RESPONSIBLE PARTY/GUARDIAN:**

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE NUMBERS:

MAILING ADDRESS: \_\_\_\_\_ HOME #: \_\_\_\_\_

\_\_\_\_\_ CELL #: \_\_\_\_\_

WORK #: \_\_\_\_\_

PARENT/GUARANTOR: FATHER'S NAME: \_\_\_\_\_

GUARANTOR PHONE #: \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_

GUARANTOR ADDRESS: \_\_\_\_\_ EMPLOYER NAME \_\_\_\_\_

\_\_\_\_\_ ADDRESS: \_\_\_\_\_

PARENT EMAIL ADDRESS: \_\_\_\_\_

**EMERGENCY CONTACT INFO:**

EMERGENCY CONTACT NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

**INSURANCE INFORMATION:**

PRIMARY INS NAME & ADDRESS: ID # \_\_\_\_\_ GROUP # \_\_\_\_\_

NAME: \_\_\_\_\_ CARDHOLDER: \_\_\_\_\_ EFF DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CARDHOLDER DOB: \_\_\_\_\_ SEX: \_\_\_\_\_

\_\_\_\_\_

PRIM INS TEL #: \_\_\_\_\_

SECONDARY INS NAME & ADDRESS: ID # \_\_\_\_\_ GROUP # \_\_\_\_\_

NAME: \_\_\_\_\_ CARDHOLDER: \_\_\_\_\_ EFF DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CARDHOLDER DOB: \_\_\_\_\_ SEX: \_\_\_\_\_

\_\_\_\_\_

**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: \_\_\_\_\_