



Registration Form

PATIENT			
First Name:	Last:	DOB: / /	M / F
Current Address:			
City:	State:	Zip:	

ADDITIONAL PATIENTS (if any)			
1. First Name:	Last:	DOB: / /	M / F
2. First Name:	Last:	DOB: / /	M / F
3. First Name:	Last:	DOB: / /	M / F
4. First Name:	Last:	DOB: / /	M / F

PARENT/GUARDIAN 1			
First Name:	Last:	(Maiden:)	DOB: / / M / F
Home Phone:	Cell Phone:		
Email Address:			
Current Address (if different from above):			
City:	State:	Zip:	

PARENT/GUARDIAN 2			
First Name:	Last:	(Maiden:)	DOB: / / M / F
Home Phone:	Cell Phone:		
Email Address:			
Current Address (if different from above):			
City:	State:	Zip:	

EMERGENCY CONTACT			
Select one:			
<input type="checkbox"/> Parent/Guardian 1 <input type="checkbox"/> Parent/Guardian 2 <input type="checkbox"/> Other (If Other, please complete below)			
First Name:	Last:	M / F	
Relationship to Patient:	Contact Phone:		

GUARANTOR (Person responsible for copayments, deductibles, and non-covered expenses)

Select one:

- Parent/Guardian 1
 Parent/Guardian 2
 Other (If Other, please complete below)

First Name:	Last:	DOB: / /	M / F
Relationship to Patient:		Contact Phone:	
Current Address (if different from above):			
City:		State:	Zip:

PRIMARY INSURANCE

Policy Holder's Name:	DOB: / /	M / F
Current Address (if different from above):		
City:		State: Zip:
Employer's Name:	Work Phone:	
Insurance Name:	Phone:	
Insurance ID:	Group #:	Effective Date: / /
***If you are an existing patient and this is a new insurance policy, please indicate the following:		
Previous Insurance Name:		Termination Date: / /

SECONDARY INSURANCE (if any)

Policy Holder's Name:	DOB: / /	M / F
Current Address (if different from above):		
City:		State: Zip:
Employer's Name:	Work Phone:	
Insurance Name:	Phone:	
Insurance ID:	Group #:	Effective Date: / /

I hereby authorize BCHP to release information concerning treatment or services rendered to my insurance carriers who are responsible for my/my dependent's care. I request payment of authorized medical benefits to be made directly to BCHP for services rendered to me/my dependent. I have been advised that co-payments not paid at the time of service will be subject to a \$15 surcharge. I understand that I am responsible for any amount determined to be my liability to the provider, including deductibles, co-payments, and non-covered services.

X _____ Date: ___/___/___

Parent/Guardian Signature