

**BCHP REGISTRATION / BCHP REGISTRO**

Date / Fecha: \_\_\_\_/\_\_\_\_/\_\_\_\_

MRN: \_\_\_\_\_

Patient's Name / Nombre del Paciente: \_\_\_\_\_

Sex / Sexo: \_\_\_\_\_ Date of Birth / Fecha de Nacimiento: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age / Edad: \_\_\_\_\_

Patient's Address / Direccion: \_\_\_\_\_ City / Ciudad: \_\_\_\_\_

State / Estado: \_\_\_\_\_ Zip Code /Codigo Postal: \_\_\_\_\_

**PARENT / GUARANTOR / PADRE O GARANTE**

Mother's Name / Nombre de la Madre: \_\_\_\_\_ Date of Birth / Fecha de Nacimiento: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer / Empleador: \_\_\_\_\_ Address / Direccion: \_\_\_\_\_

Phone Numbers / Numeros telefonicos: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Father's Name / Nombre del Padre: \_\_\_\_\_ Date of Birth / Fecha de Nacimiento: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer / Empleador: \_\_\_\_\_ Address / Direccion: \_\_\_\_\_

Phone Numbers / Numeros telefonicos: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Guarantor's Name / Nombre del Garante: \_\_\_\_\_ Date of Birth / Fecha de Nacimiento: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer / Empleador: \_\_\_\_\_ Address / Direccion: \_\_\_\_\_

Phone Numbers / Numeros telefonicos: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**RESPONSIBLE PARTY / GUARDIAN / PARTE RESPONSIBLE O GUARDIAN**

Name / Nombre: \_\_\_\_\_ Relationship / Relacion: \_\_\_\_\_

Date of Birth / Fecha de Nacimiento: \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone Numbers / Numeros telefonicos: Home / Casa (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell / Celular (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**EMERGENCY CONTACT / CONTACTO DE EMERGENCIA**

Name / Nombre: \_\_\_\_\_ Relationship / Relacion: \_\_\_\_\_ Phone Numbers / Numeros telefonicos: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name / Nombre: \_\_\_\_\_ Relationship / Relacion: \_\_\_\_\_ Phone Numbers / Numeros telefonicos: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**INSURANCE INFORMATION / INFORMACION DEL SEGURO**

**Primary Insurance / Seguro Primario**

Primary Insured / Asegurado Primario: \_\_\_\_\_ Date of Birth / Fecha de Nacimiento: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship / Relacion: \_\_\_\_\_

Name of Insurance / Nombre de Seguro: \_\_\_\_\_

Member ID# / Numero de Miembro: \_\_\_\_\_ Group # / Numero de Grupo: \_\_\_\_\_ Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**RELEASE OF INFORMATION AND ASSIGNMENT**

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 \$20 surcharge will be added to my bill.

Signature of Parent / Guardian / Firma del Padre / Guardian: \_\_\_\_\_

Date / Fecha: \_\_\_\_\_

X \_\_\_\_\_

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