Bear Pediatrics, LLC
Katie Bittner-Cassett, CRNP
2813 Bel Air Rd, Suite 100
Fallston, MD 21047
(O) 443-981-3337, (F) 443-981-3286

Patient Registration

Child's Name: _____ Date of Birth: _____ M/F

Child's Name: _____ Date of Birth: _____ M/F

Child's Name: _____ Date of Birth: _____ M/F

Child's Name: _____ Date of Birth: _____ M/F

Child's Name: _____ Date of Birth: _____ M/F

Address: _____

Phone: Home: _____ Cell:_____

Email: _____

Primary Contact Method: Email: _____ Cell: _____ Home phone: _____

Children live with: _____

Primary Language: _____ Race: _____ Ethnicity: _____

Parent 1:

Name: _____

DOB: _____

SS #: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Employer: _____

Address if different than patient:

_____

Parent 2:

Name: _____

DOB: _____

SS #: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Employer: _____

Address if different than patient:

_____

Primary Insurance: _____

Policy Holder's Name: _____

Policy Holder's DOB: _____ Policy Holder's SS #: _____

Policy ID #: _____ Policy Group #: _____ Co-Pay: _____

Secondary Insurance: _____

Policy Holder's Name: _____

Policy Holder's DOB: _____ Policy Holder's SS #: _____

Policy ID #: _____ Policy Group #: _____ Co-Pay: _____

Address Billing Statements should be sent to if **DIFFERENT** from primary address:

_____

Privacy Constraints (Check One):

_____ No Restrictions: Okay to leave message on VM and/or send mail

_____ Restrictions: Person to person with patient and/or guardian only

_____ Restrictions: _____

If parents are divorced or separated, please fill out this section:

Who has legal custody? _____

Are there any legal restrictions that would restrict the non- custodial parent from consenting to medical treatment for the child or from obtaining information regarding the child's medical treatment?

YES _____ NO _____

If **YES**, please explain **AND PROVIDE A COPY OF THE LEGAL PAPERWORK**:

_____

I authorize the release of any medical or other information necessary to process claims from Bear Pediatrics, LLC. I also request payment of government benefits either to myself or to the party who accept assignment below. I fully understand that I am financially responsible for all charges and balances remaining from claims, including charges not covered or denied by my insurance. All non-paid balances will be sent to collections within 90 days of initial notice. I have also been offered a copy of the Notice of Privacy Practice (HIPPA).

Patient Registration Signature Form

2019:

_____ _____
Signature Date

I have reviewed that above information and attest that all the information provided above is still accurate and/or any changes have been made. I have reviewed the HIPPA policy and the authorization to bill and agree with both.

2020: _____ _____
Signature Date

2021: _____ _____
Signature Date

2022: _____ _____
Signature Date

2023: _____ _____
Signature Date

2024: _____ _____
Signature Date

2025: _____ _____
Signature Date

2026: _____ _____
Signature Date

2027: _____ _____
Signature Date

2028: _____ _____
Signature Date

2029: _____ _____
Signature Date