**LEAP Health and Wellness Center**
130 N. Broadway, 10th Floor
Camden, NJ 08102
Office: 856-614-5610
Fax: 856-614-3236

# Child/Dependent Registration Form

**Today's Date**____________________________

Please complete this form and sign page 3 in order to ensure proper billing of your services.  Please print.

**Patient Information**

Patient's Last Name:__________________________________________ Social Security Number:_______________________________________

First Name:__________________________________________________ Date of Birth:________________________ Sex: M F

Other Name/AKA:_____________________________________________ Home Phone:___________________Alt. Phone:___________________

Address:____________________________________________________ Cell Phone_________________________________________________

City, State, Zip Code__________________________________________ Email Address:_____________________________________________

**Preferred Method of Contact:**

___ Alt Phone Number ___ Email ___ Letter

___ Phone Call (Cell) ___ Phone Call (Home)

**Ethnicity (Data is used for statistical reporting):**

___ Hispanic or Latino ___ Not Hispanic or Latino

___ Patient Declined

**Employment Status:**

___ Full Time ___ Part Time ___ Student

**Employer:**_________________________________________

**Race: (Data is used for statistical reporting):**

___ American Indian or Alaska Native ___Black or African American
___ Native Hawaiian/Pacific Islander
___ Asian ___ White ___ Patient Declined

Language: ___English ___Spanish ___ Other____________________________

**INSURANCE INFORMATION** (A Separate form is required for automobile liability, or legal services).

**PRIMARY CARRIER**:____________________________________________ Telephone___________________________________________

Address:____________________________________________________ Child's ID:___________________________________________

Subscriber's Name____________________________________ Group/Plan#___________________Effective Date:_______________________

Subscriber's Date of birth_________________ ___M ___ F Subscriber SS#_______________Relationship to Patient___________________

Subscriber's employer__________________________________________ PCP Listed on Card:_________________________________________

**SECONDARY CARRIER**:_________________________________________ Telephone___________________________________________

Address:____________________________________________________ Child's ID:___________________________________________

Subscriber's Name____________________________________ Group/Plan#___________________Effective Date:_______________________

Subscriber's Date of birth_________________ ___M ___ F Subscriber SS#_______________Relationship to Patient__________________

Subscriber's employer___________________________________________ PCP Listed on Card:_______________________________________

| **GUARANTOR INFORMATION** (Guarantor is the person financially responsible for this patient's bill.) | |
|---|---|

Guarantor:___________________________________________ Patient's Relationship to Guarantor:____________________________________

Address:_____________________________________________ Social Security Number:______________________________________________

City, State, Zip Code___________________________________ Date of Birth:_________________________________ Sex: M F

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**GUARANTOR INFORMATION** (continued)

Employer:___________________________________________________________ Home Phone ___________________________________________

Address:____________________________________________________________ Work Phone___________________________________________

City, State, Zip Code___________________________________________________ Cell Phone____________________________________________

Driver's License No.______________________________________State________ Email Address_________________________________________

**OTHER PARENT OR GUARDIAN**

Parent/Guardian:_____________________________________________________ Patient's Relationship to Guardian:________________________

Address:___________________________________________________________ Social Security No. _____________________________________

City, State, Zip Code___________________________________________________ Date of Birth:__________________________Sex: M F

Employer:__________________________________________________________ Home Phone__________________________________________

Address:___________________________________________________________ Cell Phone___________________________________________

Work Phone_________________________________________________________ Driver's License No.________________________State_______

**EMERGENCY CONTACT INFORMATION** (Someone living outside of the primary household)

Last Name, First Name__________________________________________________ Patient's Relationship to Contact__________________________

Address:____________________________________________________________ Home Phone: _________________________________________

City, State, Zip Code:___________________________________________________ Work Phone__________________________________________

Cell Phone__________________________________________

**LIST OF ALL CHILDREN/SIBLINGS**

| Child #1 Last Name | First Name | Date of Birth |
|---|---|---|
| Child #2 Last Name | First Name | Date of Birth |
| Child #3 Last Name | First Name | Date of Birth |
| Child #4 Last Name | First Name | Date of Birth |

**CHILD/DEPENDANT REGISTRATION (CONTINUED)**

**ASSISGNMENT OF BENEFITS/AUTHORIZATION/NOTICE OF COLLECTION ACTION**

I understand I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I further understand that all co-payments are due at time of service and I am also responsible to pay other amounts due; these amounts may include annual deductibles, charges denied by my insurance company as not covered or not medically necessary, and/or any fees incurred should my account require collection action. (E.G. late fees, collection agency, court or attorney costs). Also, please be advised our office may contact you via an automated system regarding appointments and/or account status. I agree this authorization shall remain valid unless/until I rescind in writing. (Please see the Payment Policy and Notice of Privacy Practices for more information).

**USE OF PHOTOGRAPH**

The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's record and may be used by the patient's health care provider solely for the purposes of patient identification.

**NEW JERSEY VACCINE REGISTRY (if applicable)**

Please be advised that our office submits confidential data of children and adult vaccinations to the NJISS (New Jersey Immunization Information System) per the Statewide Immunization Registry Act. The purpose of this program is to keep a central record of patient's immunization history.

**SIGNATURE REQUIRED**

The undersigned acknowledges that I have read and understand the above terms and conditions.

_______________________________________________ _______________________________________

Patient Name (Please Print) Patient Signature

______________________________________________________________________Date__________________

Guarantor/Parent/Guardian completing this form (Please print)

______________________________________________________________________Date___________________

Guarantor/Parent/Guardian Signature