Capitol Pediatrics, P.C.
Registration Form

How did you hear about us? _____

Child's Information

Name: _____ DOB: _____ SSN: _____
Address: _____ City/State/Zip: _____
Home Phone: _____ Cell Phone: _____ Email: _____
Emergency Contact (other than parent) _____
Name Phone Relationship
Race/Ethnicity: _____ Preferred Language: _____

Sibling Information

LAST NAME	FIRST NAME	BIRTHDATE	SEX	SSN

Parent #1 Information

Name: _____ Sex: _____
Address: _____
City/State/Zip: _____
Date of Birth: _____
SSN: _____
Email: _____
Home Phone: _____
Cell Phone: _____
Employer: _____
Work Phone: _____

Parent #2 Information

Name: _____ Sex: _____
Address: _____
City/State/Zip: _____
Date of Birth: _____
SSN: _____
Email: _____
Home Phone: _____
Cell Phone: _____
Employer: _____
Work Phone: _____

** Please note that parent's social security numbers will be needed for identification purposes. All numbers are secured. **

Insurance Information

Primary Insurance: _____ Subscriber: _____
Secondary Insurance: _____ Subscriber: _____

WHO IS RESPONSIBLE FOR THE BILL? _____

I agree to notify Capitol Pediatrics, P.C. of any address, telephone, or employer changes immediately. I hereby authorize Capitol Pediatrics, P.C. to release all necessary information to the insurance company for filing claims as well as other physicians when care is being coordinated. I hereby assign payment directly to Capitol Pediatrics, P.C. of benefits otherwise payable to me. I authorize Capitol Pediatrics, P.C. to file complaints to the insurance company and the insurance commissioner on my behalf. I understand that I am required to show my current insurance card and pay any copays/coinsurance at each visit. I understand that I am financially responsible for charges not covered by insurance. If my account should be placed with an attorney for collection, I agree to pay, in addition to all other amounts I owe, an attorney's fee equal to one-third percent (33.3%) of my outstanding balance and other costs associated with collections. If any indebtedness is not paid in full within 30 days from the date of invoice, I agree to pay an interest charge of 1.5% per month (18% per annum). Chesterfield County shall be the proper jurisdiction and venue for any collection action. If we do not hear from you within this 35-day period, we will transfer your account to D. Kent Gilliam, P.C. We are providing your email address to D. Kent Gilliam, P.C., who may use this email address to communicate with you about any debt. If others have access to this email address, then it is possible they may see the emails. If you would like to opt out of email communications with D. Kent Gilliam, P.C., please notify us within this 35-day period.

Parent's Printed Name: _____ Date: _____
Parent's Signature: _____