TriHealth Physician Partners
Queen City Physicians

Print Form

Account No. _____

QUEEN CITY PHYSICIANS PATIENT REGISTRATION FORM

CHILD'S LEGAL NAME	BIRTHDATE	GENDER	SOC. SEC. #	CHILD LIVES WITH	ETHNICITY	RACE	LANGUAGE

Name of Person Responsible for Bill _____

Billing Address _____ (Street) _____ (City) _____ (State) _____ (Zipcode)

Billing Phone _____

Mother's Name _____ Marital Status ◯ M ◯ D ◯ S ◯ W ◯ Sep

Smoker _____ Parental Status _____ Birthdate _____ SSN _____

Home Address _____ (Street) _____ (City) _____ (State) _____ (Zipcode)

IF NOT SAME AS BILLING ADDRESS

Home Phone _____ Cell Phone _____ Email _____

Employer _____ Occupation _____ Work Phone _____

Father's Name _____ Marital Status ◯ M ◯ D ◯ S ◯ W ◯ Sep

Smoker _____ Parental Status _____ Birthdate _____ SSN _____

Home Address _____ (Street) _____ (City) _____ (State) _____ (Zipcode)

IF NOT SAME AS BILLING ADDRESS

Home Phone _____ Cell Phone _____ Email _____

Employer _____ Occupation _____ Work Phone _____

INSURANCE INFORMATION ☐ CHANGED ☐ SAME

1st Insurance Coverage _____ Office Co-Pay _____

Subscriber Name _____

Subscriber Employer _____

Insurance ID Number _____ Effective Dates _____

Gender _____ Birthdate _____ SSN _____

Relationship of Patient to Policyholder ☐ Self ☐ Spouse ☐ Dependent

2nd Insurance Coverage _____ Office Co-Pay _____

Subscriber Name _____

Subscriber Employer _____

Insurance ID Number _____ Effective Dates _____

Gender _____ Birthdate _____ SSN _____

Relationship of Patient to Policyholder ☐ Self ☐ Spouse ☐ Dependent

IN CASE OF EMERGENCY NOTIFY (Someone not in Patient's Household

Contact Name _____ Relationship to Patient _____

Contact Address _____ _____ _____ _____

Street City State Zipcode

Home Phone _____ Work Phone _____

List name of person who referred you to Queen City Physicians and check category below

Referral Name _____

☐ Emergency Room ☐ Doctor ☐ Family/Friend ☐ Insurance Co ☐ Yellow/White Pages ☐ Other

AUTHORIZATION

By signature below I state the above information to be true and correct. I hereby authorize the physicians of Queen City Physicians, to treat the patient named above for medical and surgical procedures on scheduled or emergency basis at any location and to submit a claim to my insurance carrier(s) or its intermediaries for all services rendered by the physician or their agents and hereby direct my insurance carrier(s) or its intermediaries to issue payment DIRECTLY to QUEEN CITY PHYSICIANS on behalf of such rendered services. I understand that I am financially responsible to this office for any balance not covered by my insurance carrier. **A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.**

Signature _____ Date _____

In the event that the parent(s) legal guardian(s) are unable to accompany the child during an office visit, I hereby authorize the physicians of QUEEN CITY PHYSICIANS to evaluate and treat any and all conditions that require immediate attention.

Signature _____ Date _____

Acknowledgment of Receipt of Notice of Privacy Practices: The undersigned Patient, Parent or Legal Guardian of the Patient, acknowledges that he or she personally received a copy of the Queen City Physicians Notice of Privacy Policies on the date indicated below.

Signature _____ Date _____

Acknowledgment of Receipt of QCP Financial Policy: I have received a copy of the Queen City Physicians Financial Policy and understand that I am ultimately responsible for the charges incurred by my child/children as their legal parent or guardian.

Signature _____ Date _____