NEW PATIENT REGISTRATION

LAST NAME: _____

FIRST NAME:_____ **D.O.B. ____/____/____** **M__ F__**

LAST NAME: _____

FIRST NAME:_____ **D.O.B. ____/____/____** **M__ F__**

LAST NAME: _____

FIRST NAME:_____ **D.O.B. ____/____/____** **M__ F__**

Emergency Contact:_____ **Phone _____**

Preferred Pharmacy _____ **Phone _____**

How did you hear about our practice: _____

Parents Information

Parent Name: _____ **Cell: _____**

Parent Name: _____ **Cell: _____**

Home Phone _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Insurance Information

Name of Insurance Company: _____
ID #: _____ Group#: _____ Effective Date ____/____/____
Ins. Address: _____ City: _____ State: _____ Zip _____
Insurance Policy Holder: _____ D.O.B.: _____/_____/_____
Employer's Name:_____ Phone #: _____
Employer's Address: _____

<u>Authorization of treatment and assignments of benefits:</u>

I authorize Pediatric Associates of Westfield to treat my child/children. I further authorize the release of medical information necessary for the completion of insurance forms, school & camp forms. I authorize payment directly for all medical claims to Pediatric Associates of Westfield. I understand that I am responsible for all co-payments at the time of service and any charges not covered by my insurance plan. I also understand that I am responsible for advising the office of any changes to my insurance and demographics. If you have health insurance coverage, you must call your Insurance carrier immediately to enroll your baby. The telephone number is listed on your health insurance identification card. Most insurance companies allow very little time for this enrollment and will deny coverage for your baby if they are not notified within 15-30 days of your baby's birth.

Signature: _____ Date: _____/_____/_____