

Greenwich Pediatric Associates
Patient Registration Form
NEW PATIENTS

PATIENT INFORMATION:

CHILD NAME: _____ DOB _____ M/F
NICKNAME: _____
CHILD NAME: _____ DOB _____ M/F
NICKNAME: _____
CHILD NAME: _____ DOB _____ M/F
NICKNAME: _____
CHILD NAME: _____ DOB _____ M/F
NICKNAME: _____

CHILD LIVES WITH: MOTHER/FATHER GUARDIAN: _____
MARITAL STATUS: SINGLE/MARRIED OTHER: _____

MOM NAME _____ **DOB** _____ **SS#** _____ - _____ - _____
DAD NAME _____ **DOB** _____ **SS#** _____ - _____ - _____

PATIENTS ADDRESS: _____
NO PO BOX
CITY: _____ STATE: _____ ZIP _____

MOM HOME PHONE:() _____ **DAD HOME PHONE:**() _____
MOM WORK PHONE:() _____ **DAD WORK PHONE:**() _____
MOM CELL PHONE:() _____ **DAD CELL PHONE:**() _____

MOM EMPLOYER'S NAME: _____
ADDRESS: _____
DAD EMPLOYER'S NAME: _____
ADDRESS: _____

NAME & PHONE NUMBER OF PERSON TO CONTACT IN CASE OF AN EMERGENCY (NOT AN IMMEDIATE FAMILY MEMBER):
_____ () _____

DRIVER'S LICENCE #: _____ **STATE:** _____
EXP. DATE: _____ **OPERATOR'S NAME:** _____

PATIENT INSURANCE INFORMATION
PLEASE PRESENT CARD(S) TO THE RECEPTIONIST

TYPE OF INSURANCE: _____
POLICY HOLDER'S NAME: _____
POLICY ID #: _____

AUTHORIZATION & ASSIGNMENT OF BENEFITS

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY FOR THE COMPLETION OF INSURANCE FORMS. IF BILLED DIRECTLY, I GIVE LIFETIME CONSENT FOR PAYMENT TO *Greenwich Pediatric Associates* FOR ALL MEDICAL OR SURGICAL BENEFITS OTHERWISE PAYABLE TO ME UNDER THE TERMS OF MY INSURANCE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CO-PAYMENTS AT THE TIME OF SERVICE AND ANY CHARGES NOT COVERED BY MY INSURANCE. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. THE POLICY OF OUR OFFICE, AS WELL AS THE STATE OF CONNECTICUT, IS THAT THE PARENT WHO REQUESTS TREATMENT FOR THE CHILD IS RESPONSIBLE FOR ALL FEES FOR SERVICE RENDERED.

PATIENT OR AUTHORIZED SIGNATURE DATE