

Greenwich Pediatric Associates
Patient Registration Form
EXISTING 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: _____

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:() _____

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