WESTFIELD PEDIATRICS, P.A.
Registration Form

All information must be completed in order to bill your insurance carrier. If the information is not received at the time of service, you will be responsible for the bill.

Today's Date: _____ Primary Care Physician: _____

Patient Information:

Patient Name_____ Date of Birth (DOB)_____ □ M □ F
Address_____ City_____ State_____ Zip _____
Telephone _____ Social Security# _____

Siblings (list all) Children live with: □ Parents □ Mother □ Father □ Other

Name_____ DOB _____ Sex _____
Name_____ DOB _____ Sex _____
Name_____ DOB _____ Sex _____
Name_____ DOB _____ Sex _____

Parent Information

Parent's Name_____
Address_____
City_____ State _____ Zip_____
Telephone (h) _____
(cell) _____
Employer _____
Occupation_____
E-mail address_____
Social Security #_____DOB_____

Parent's Name_____
Address _____
City _____ State _____Zip_____
Telephone (h) _____
(cell) _____
Employer _____
Occupation _____
E-mail address_____
Social Security #_____DOB_____

Insurance Information: (PLEASE ALSO ATTACH FRONT/BACK COPY OF ID CARD)

Primary Policy Holder _____
Insurance Co. _____
Ins Address _____
_____
Policy #_____
Group #_____ Effective Date_____
Employer _____
Relationship to Patient _____
Social Security # _____ DOB _____

Secondary Policy Holder _____
Insurance Co._____
Ins Address_____
_____
Policy #_____
Group #_____ Effective Date _____
Employer _____
Relationship to Patient_____
Social Security #_____DOB _____

Financially Responsible Party: (IF OTHER THAN POLICY HOLDER)

Name: _____ Date of Birth: _____
SSN: _____-_____-_____
Address: _____
City: _____ State: _____ Zip: _____
H#_____-_____-_____ W#_____-_____-_____

Assignment of Benefits:

I understand that I am responsible for the accuracy of the information I have provided on this form. I authorize payment of medical and/or surgical benefits directly to Westfield Pediatrics, PA, for all services rendered. I also authorize release of any medical and/or other information necessary for the processing of claims. If for any reason payment may not be made by my insurance carrier, I will be held responsible for all fees incurred with Westfield Pediatrics, PA, as well as all costs associated with any collection agencies and/or attorney fees. I have received the Westfield Pediatrics, PA Notice of Privacy Practice as it relates to my child or me as defined by state and federal regulations. In addition, I understand that the parent who brings the child to the office for medical services is responsible AT THE TIME OF SERVICE for co-payments, deductibles, balances and for payment in full if the provider of service is non participating with my insurance carrier.

Patient/Parent/Legal Guardian Signature:_____ Date:_____