

PEDIATRIC ASSOCIATES OF WESTFIELD

REGISTRATION FORM

(Please Print)

Today's Date ____/____/____

PCP _____

PATIENT INFORMATION

Patient's Last Name	First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address	City	State	ZIP Code	Social Security No. - -	Home Phone No. ()	
P.O. Box	City	State	ZIP Code			
Occupation	Employer			Employer Phone No. ()		
Chose Office Because: Referred by (Please check one box) <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Insurance Plan _____ <input type="checkbox"/> Hospital <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to Home/Work <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other _____						
Other Family Members Seen Here _____						

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)		Home Phone No. ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation	Employer	Employer Address		Employer Phone No. ()	
Is patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate primary insurance: <input type="checkbox"/> OXFORD <input type="checkbox"/> UNITED HEALTH CARE <input type="checkbox"/> CIGNA <input type="checkbox"/> BC/BS <input type="checkbox"/> HEALTHNET <input type="checkbox"/> LOCALS # <input type="checkbox"/> GUARDIAN <input type="checkbox"/> AETNA <input type="checkbox"/> OTHER _____					
Subscriber's Name	Social Security No. - -	Birth Date / /	Group Number	Policy Number	Co-Payment \$
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					
Name of Secondary Insurance (if applicable)	Subscriber's Name		Group Number	Policy Number	
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone Number ()	Work Phone Number ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Pediatric Associates or insurance company to release any information required to process my claims.

X _____
PATIENT/GUARDIAN SIGNATURE DATE