PEDIATRIC ASSOCIATES
OF WESTFIELD

NEW PATIENT REGISTRATION

LAST NAME:_____ D.O.B._____/_____/_____ M__ F____

FIRST NAME:_____ D.O.B._____/_____/_____ M__F____

_____ D.O.B._____/_____/_____ M__F____

Emergency Contact :_____ Phone:_____

Preferred Pharmacy:_____ Phone :_____

How did you hear about our practice:_____

Parents Information

Mom Name: _____ Cell: _____

Dad 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:____/_____/_____ SSN:_____

Employer's name:_____ Phone #:_____

Employer's address:_____

Authorization of treatment and assignments of benefits:

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 :**_____/_____/_____