Patient Pre-Registration form:

Please complete and return to our office at least 2 business days before your scheduled appointment.

Child's First Name	Child's Last Name	Date of Birth	Gender
		/ /	Male
		/ /	Male
		/ /	Male
		/ /	Male

Parent #1/Legal Guardian:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Home Phone #: (_____) _____
Cell Phone #: (_____) _____
Work Phone #: (_____) _____
Email Address: _____
Social Security Number: _____
Relationship to Patient: _____
Marital Status: Married ☐ Single ☐
Separated ☐ Divorced ☐ Widowed ☐
Employer: _____
Employer Address: _____
City: _____ State: ____ Zip: _____

Parent #2/Legal Guardian:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Home Phone #: (_____) _____
Cell Phone #: (_____) _____
Work Phone #: (_____) _____
Email Address: _____
Social Security Number: _____
Relationship to Patient: _____
Marital Status: Married ☐ Single ☐
Separated ☐ Divorced ☐ Widowed ☐
Employer: _____
Employer Address: _____
City: _____ State: ____ Zip: _____

Has Custody (Select One)? ◉ Both ○ Father ○ Mother ○ Other: _____
Child Lives With (Select One)? ◉ Both ○ Father ○ Mother ○ Other: _____
Which Parent Will Bring in Patient(s) Most Often (Circle One): ○ Both ○ Father ○ Mother ○ Other:
Preferred pharmacy: _____

Emergency Contact (Other Than Parent):
Name: _____
Cell Phone #: (_____) _____
Relationship to Patient: _____

INSURANCE INFORMATION – Insurance card(s) must be presented at <u>every visit</u> to process claims.

Primary Insurance

Insurance Company: _____
Insurance Effective Date: _____
ID #: _____
Group #: _____
Subscriber's Name: _____
Subscriber's Date of Birth: _____

Secondary Insurance

Insurance Company: _____
Insurance Effective Date: _____
ID #: _____
Group #: _____
Subscriber's Name: _____
Subscriber's Date of Birth: _____

I hereby authorize my insurance benefits to be paid to Pediatrics at Newton Wellesley, PC and acknowledge that I am responsible for any balance not covered by those benefits. Delinquent accounts will be submitted to a collection agency, and any collection fees will be the parent/gaurdian/gaurentor's responsibility. In cases of divorce or separation, unless otherwise specified by a court order, both parents will be permitted to bring the child(ren) into the office and have full access to your child(ren)'s medical records.

_____ _____
Patient's Signature or Parent/Guardian (if minor) Date

Please return via fax/email

email: pedsnw.om@chppoc.org |fax: 617-928-0178