Northeast Pediatrics

Patient Registration

Child's Name: _____ **DOB**: _____
Last First MI

Gender: M F Nickname: **Current Grade in School:**

Home Address: **Apt/Unit Number:**

City: **State:** **Zip Code:**

Home Phone Number: **Cell Phone:** **Best phone number to reach you?**

Email: **Ok to send office updates via email?**

Child lives with: **Whom can we thank for this referral?**

Family Information

Father/Guardian's Name: **Address (if different):**

Home Phone: **Work Phone:** **Cell Phone:** **DOB:**

SSN: **Drivers License #/State:** **Employer:**

Mother/Guardian's Name: **Address (if different):**

Home Phone: **Work Phone:** **Cell Phone:** **DOB:**

SSN: **Drivers License #/State:** **Employer:**

Siblings Name: **DOB:** **Siblings Name:** **DOB:**
Siblings Name: **DOB:** **Siblings Name:** **DOB:**

Insurance Information

Insurance Subscribers Name:

Plan: **Policy Number:** **Group Number:**

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my child/minor's medical status and/or insurance.
I certify that my child/minor has insurance coverage with _____ and is assigned directly to Northeast Pediatrics for all insurance benefits, if any, otherwise payable by me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature of Parent/Guardian: _____ Date: _____

❒ I have read and understand the Northeast Pediatrics Patient Policies.

Emergency Contacts

In the event of an emergency, who should contact(other then parent/guardian):
Name:_____ Relationship:_____ Phone: _____
Name:_____ Relationship:_____ Phone: _____