PATIENT REGISTRATION FORM

Weymouth Pediatrics PC
851 Main Street, Suite 25
Weymouth MA 02190

Today's Date: ________________________

PATIENT INFORMATION:

Last Name: _________________________ First Name: ___________________________

Date of Birth: _______________________________ Age: _________ Sex: _______
(MM/DD/YYYY)

Address: ____ Apt_______________

City: ____ State: _________ Zip: __________________

Home Phone: (________) _________ -_______________

Cell Phone: (________) ____________ -_____________

E-mail Address: ____

Emergency Contact Name: ____

Emergency Phone: (________) ___________-_____________

Parents

Mother's Name: _____ ___________________________________ Birth Date_________________

Address (if different): ____ Apt____________

City: ____ State: _________ Zip: ________________

Occupation ______________________

Phone: _________________________

Email: ____

Father's Name: ____Birth Date____________________

Address (if different) ____

Phone: ____

Occupation ____________________________________

Health Insurance Information

Primary Insurance Company ____

Subscriber's Name ____

Relation to Child _________________________________

Subscriber # ___________________________________

Subscriber's Date of Birth __________________________

PATIENT REGISTRATION FORM DISCLOSURES & CONSENTS

Patient Name: ____

Date of Birth: _________________

Acknowledgement of Receipt of Notice of Privacy Practices: Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of the Weymouth Pediatrics Notice of Privacy Practices (Notice) on the date indicated. A copy of this policy is posted in the waiting room, also available on the practice's website. If you have any questions regarding the information in the Notice of Privacy Practices, please do not hesitate to contact one of our staff.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize direct payment of my insurance benefits to Weymouth Pediatrics for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Weymouth Pediatrics PC is unable to collect from my insurance carrier for whatever reason.

Patient Name: ____

Date of Birth: ________________

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION: I hereby authorize Weymouth Pediatrics to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL: I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize Weymouth Pediatrics representative or my physician to mail, call, or e-mail me with communications regarding me or my dependent's healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Weymouth Pediatrics PC to that effect in writing.

CONSENT TO TREATMENT: I hereby consent to evaluation, testing, and treatment of me or my dependent as directed by my Weymouth Pediatrics physician or his or her designee.

Parent/Guardian

Signature______________________________________Date: _____/_____/__________

Name of guardian: ____

Form Update: 01/08/2016