

NORTHAMPTON AREA PEDIATRICS, LLP

Patient Registration Form

New Patient

Update Est.

Patient Information:

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Child #1 Name: Last _____ First _____ MI _____

Social Security #: _____ Date of Birth: _____ Sex: M F

Insurance ID #: _____

Child #2 Name: Last _____ First _____ MI _____

Social Security #: _____ Date of Birth: _____ Sex: M F

Insurance ID #: _____

Child #3 Name: Last _____ First _____ MI _____

Social Security #: _____ Date of Birth: _____ Sex: M F

Insurance ID #: _____

Child #4 Name: Last _____ First _____ MI _____

Social Security #: _____ Date of Birth: _____ Sex: M F

Insurance ID #: _____

Primary Insurance Information:

Policy Holder Name: _____

Policy Holder's Date of Birth: _____ Relation to Patient: _____

Policy Holder's SS #: _____ Effective Date: _____

Insurance Company Name: _____ Ins. Phone #: _____

Policy #: _____ Group #: _____

Secondary Insurance Information:

Insurance Company Name: _____ Ins. Phone #: _____

Insured / Card Holder's Name: _____ Effective Date: _____

Policy #: _____ Group #: _____

Emergency Contact – Other than Parent / Legal Guardian:

Name: _____ Relationship: _____

Address: _____

Phone: _____ Phone: _____

Complete Questions on other side

Parent / Legal Guardian Information:

Parent / Legal Guardian #1:	Parent / Legal Guardian #2:
Name:	Name:
Social Security #:	Social Security #:
Date of Birth:	Date of Birth:
Street Address:	Street Address:
City: State: Zip:	City: State: Zip:
Home Phone:	Home Phone:
Work / Cell Phone:	Work / Cell Phone:
Email:	Email:
Employer:	Employer:

Step Parent / Other Information:

Step Parent / Other #1:	Step Parent / Other #2:
Name:	Name:
Relationship:	Relationship:
Date of Birth:	Date of Birth:
Street Address:	Street Address:
City: State: Zip:	City: State: Zip:
Home Phone:	Home Phone:
Work / Cell Phone:	Work / Cell Phone:
Employer:	Employer:

I understand that payment of all medical care is due at the time of service. In the case of separated parents, responsibility and payment shall be the responsibility of the guardian bringing the child in for treatment. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company.

I authorize the release of medical information to my insurance company that is necessary to process medical claims. I authorize payment directly to Northampton Area Pediatrics, LLP for services provided.

Parent / Guardian Signature: _____

Guarantor Signature: _____

Date: _____

