West Haven Pediatrics
Patient Registration Form
2018

Patient Information:

Name:____DOB:____/____/____ Sex: M or F
Primary Parent Name and Phone: ____
Primary Email Address:____
Secondary Parent Name and Phone:____
Patient Street Address:______________________________City:____________Zip Code:____________
Patient Social Security Number:_____-____-_______
Patient Nationality:______________________ Patient Primary Language:_________________________
Emergency Contact Name, Relation and Phone:____
Address:____________________________________City:__________State: _____Zip Code:__________

Pharmacy Information:

Name:____Phone:___________________________
Street Address:______________________________________City:______________________________

Insurance Information:

Insurance Company:_________________________________ ID Number:_________________________
Insured's Name:____ Insured's DOB: ____/____/____
Insured's Social Security Number: _____-____-_______ Relationship to Patient:____________________
Insured's Address:____________________________City:__________State: _____Zip Code:__________
Insured's Phone Number:____________
Additional Insurance Company (If applicable):__________________ ID Number:____________________
Insured's Name:____ Insured's DOB: ____/____/____
Insured's Social Security Number: _____-____-_______ Relationship to Patient:____________________
Insured's Address:____________________________City:__________State: _____Zip Code:__________
Insured's Phone Number:____________

Personal Responsible for Account:

Name:____Relationship to Patient:_________________
Address:_______________________________City:__________State: ______Zip Code:____________
DOB:____/____/____Phone Number:____________ Social Security Number: _____-____-_______

I hereby authorize payment directly to West Haven Pediatrics for all insurance benefits otherwise payable to me for services rendered. I understand I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above provider in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party:____Date:_____________