Commonwealth Pediatrics Registration Form

Patient Information

Patient's Name _____ DOB ____/____/____ SSN: _____ M / F
***Ethnicity: Hispanic/Non-Hispanic/Unknown Race: Asian/ Black/Hawaiian/White Primary Language:* _____**

Siblings seen here: _____ DOB ____/____/____ SSN: _____ M / F
***Ethnicity*: Hispanic/Non-Hispanic/Unknown *Race*: Asian/ Black/Hawaiian/White *Primary Language*: _____**

_____ DOB ____/____/____ SSN: _____ M / F
***Ethnicity*: Hispanic/Non-Hispanic/Unknown *Race*: Asian/ Black/Hawaiian/White *Primary Language*: _____**

_____ DOB ____/____/____ SSN: _____ M / F
***Ethnicity*: Hispanic/Non-Hispanic/Unknown *Race*: Asian/ Black/Hawaiian/White *Primary Language*: _____**

NEW PATIENTS ONLY

- How did you hear about our office?
OBGYN Family/Friend Baby Fair T.V. Ad Website Other: _____

- Did you have a Prenatal Consultation with us? Yes No

Please fill out information for both parents below:
Parent/Legal Guardian Information

Last Name: _____ First Name: _____

Address: _____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Place of Employment: _____ Occupation: _____

Relationship to Patient: _____ DOB: _____ SS# _____

Parent/Legal Guardian Information

Last Name: _____ First Name: _____

Address: _____ City: _____State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Place of Employment: _____ Occupation: _____

Relationship to Patient: _____ DOB: _____ SS#: _____

If parents are divorced or separated, please also fill out the section below:
Who does patient primarily live with? Name/relationship:_____/_____
Who has custody? _____ Is custody joint or exclusive? _____
Are there legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or obtaining information about the child's medical treatment? Yes No
If yes, please explain and provide a copy of the legal paperwork that supports this restriction.
_____

How would you like to be contacted regarding (circle ONLY one per category):

Medical issues: Home Phone/ Work Phone/ Cell Phone/ Home Email

Appointment Reminders: Home Phone/ Cell Phone/ Home Email/ Work Email

Recall Notices: Home Address/ Home Phone/ Work Phone/ Cell Phone/ Home Email

Patient Portal Notifications: Home Email: _____

Health Insurance Information

Insurance Name: _____ Effective Date: _____

Insured's Name: _____ Insured's DOB: _____

Insured's SSN: _____ Relationship to Patient: _____

Policy #: _____ Group #: _____

Secondary Health Insurance Information *(If applicable)*

Insurance Name: _____ Effective Date: _____

Insured's Name: _____ Insured's DOB: _____

Insured's SSN: _____ Relationship to Patient: _____

Policy #: _____ Group #: _____

I authorize payment of medical benefits be made directly to Commonwealth Pediatrics, PSC. I authorize the release of medical information needed to process any medical claim. I understand that I am financially responsible for all charges whether or not covered by my insurance. I permit a copy of this authorization to be used in the place of the original.

_____ _____

****Authorized Parent/Guarantor Signature** **Date**

**The guarantor is the person responsible for the patient's bill. The guarantor will receive all statements on the above listed patients. Our Financial Policy is available online at cwpediatrics.com or you may request a copy in our office

cwpeds Commonwealth Pediatrics

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