Commonwealth Pediatrics Patient Registration Form

Patient Information

Patient's Name: _____ DOB ____/____/____ SSN: _____ M / F

Siblings seen here: _____ DOB ____/____/____ SSN: _____ M / F

_____ DOB ____/____/____ SSN: _____ M / F

_____ DOB ____/____/____ SSN: _____ M / F

NEW PATIENTS ONLY

1. How did you hear about our office?

OBGYN Family/Friend Baby Fair Website Social Media Other: _____

2. 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.

_____

_____
Initial

I authorize that the following communications from the practice be delivered to me by the provided electronic means. I understand that some forms of electronic communications may not be secure, creating a risk of improper disclosure to unauthorized individuals.
I am willing to accept that risk, and will not hold the practice responsible should such incident occur.

Communications (check all that apply)

_____ Email Primary Email Address: _____

_____ SMS Text Messaging

Appointment reminders and recalls will be sent via text message unless otherwise requested.

Health Insurance Information

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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