



REGISTRATION FORM

Today's date:				PCP:				
PATIENT INFORMATION								
Patient's last name:		First:		Middle:		Age:	Birth date: / /	
Patient's Social Security no. (optional):						Sex: <input type="checkbox"/> M <input type="checkbox"/> F		
Primary Legal Guardian:				Relationship to Patient:				
Street address:				Preferred phone no.: ()				
P.O. box:		City:		State:		ZIP Code:		
E-Mail (for monthly e-newsletter and to forward advanced paperwork if needed):								
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr. _____		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other: _____			
Other family members seen here:								
Secondary Legal Guardian:				Relationship to Patient:				
Contact Information if Different than Primary Legal Guardian (mailing address, phone, e-mail):								
INSURANCE INFORMATION								
Person responsible for bill:		Birth date: / /		Address (if different):		Home phone no.: ()		
Occupation:	Employer:	Employer address:				Employer phone no.: ()		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Please indicate primary insurance		<input type="checkbox"/> Harvard	<input type="checkbox"/> Tufts	<input type="checkbox"/> Blue Cross		<input type="checkbox"/> Other: _____	<input type="checkbox"/> Mass Health	
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:		Policy no.:	Co-payment: \$	
Patient's relationship to subscriber:								
Name of secondary insurance (if applicable):			Subscriber's name:		Group no.:	Policy no.:		
Patient's relationship to subscriber:								
IN CASE OF EMERGENCY								
Name of local friend or relative (not living at same address):			Relationship to patient:		Home phone no.: ()	Work phone no.: ()		
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Performance Pediatrics or insurance company to release any information required to process my claims.								
_____ <i>Guardian signature</i>				_____ <i>Date</i>				