REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's Full Legal Name (Last, First, Middle)	**Date of Birth** / /
Patient SS#	**Sex** ❑ **M** ❑ **F**
Primary Legal Guardian	**Relationship to Patient**
Street address:	**Preferred phone number** ( )

P.O. box:	**City:**	**State:**	**ZIP Code:**

Primary Language: _____ **English** _____ **Other:** _____ **Second Language:** _____

Patient's Race: _____**American Indian or Alaska Native** _____ **Asian** _____**White**
_____**Black or African American** _____**Native Hawaiian or Other Pacific Islander**

Patient's Ethnicity: _____**Hispanic or Latino** _____**Not Hispanic or Latino**

Email :

Chose clinic because/Referred to clinic by (please check one box): ❑ **Dr.** ❑ **Insurance Plan**

❑ **Hospital** ❑ **Family** ❑ **Friend** ❑ **Close to home/work** ❑ **Yellow Pages** ❑ **Other**

Other family members seen here

Secondary Legal Guardian	**Relationship to Patient**

Contact Information if different than primary legal guardian:

Address: **phone:** **email:**

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	**Phone:**	**Address (if different):**	**Email:**
SS#			

Is this patient covered by insurance? ❑ **Yes** ❑ **No**

Please indicate primary insurance ❑ **Harvard** ❑ **Blue Cross** ❑ **Tufts** ❑ **Mass Health** ❑ **Other** _____

Subscriber's name:	**Date of Birth:**	**Patient's relationship to subscriber:**

Please indicate secondary insurance ❑ **Harvard** ❑ **Blue Cross** ❑ **Tufts** ❑ **Mass Health** ❑ **Other** _____

Subscriber's name:	**Date of Birth:**	**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.

Guardian signature **Date**