Community Pediatrics, P.C.
1 Billings Road
Quincy, MA 02171
Tel: (617) 773-5400

PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ Age: _____ Male: _____ Female: _____

Home Address: _____

Home Phone: _____ E-mail Address: _____

Mother Name: _____ DOB: _____ Cell: _____

Father Name: _____ DOB: _____ Cell: _____

Who may us thank you for referring you? _____ Relation to the patient: _____

In case of emergency who should be notified?

Name: _____ Telephone: _____ Relation to the patient: _____

MEDICAL INSURANCE(S) INFORMATION

Person Responsible for Account: _____

Relation to Patient: _____ Birthdate: _____ Phone #: _____

Address (if different from patient) _____

Person Responsible Employed By: _____ Occupation: _____

Business Address: _____ Work: _____

Primary Insurance: _____

Subscriber ID: _____ Group #: _____

Secondary Insurance: _____ ID #: _____

Name of other dependents covered under this plan:

_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent, have insurance coverage with _____ and assign directly to **Community Pediatrics** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named office may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is complete.

Signature of the patient (or person authorized to sign for patient): _____

Relationship to Patient: _____ Date: _____