Center for Pediatric Medicine

Our Family Caring For Yours

Patient Registration Form

Patient(s):

Last name:___________________________ First name: _________________________ M.I.__   DOB: _______________________________ Sex: __________
Last name:___________________________ First name: _________________________ M.I.__   DOB: _______________________________ Sex: __________
Last name:___________________________ First name: _________________________ M.I.__   DOB: _______________________________ Sex: __________
Last name:___________________________ First name: _________________________ M.I.__   DOB: _______________________________ Sex: __________
Last name:___________________________ First name: _________________________ M.I.__   DOB: _______________________________ Sex: __________
Last name:___________________________ First name: _________________________ M.I.__   DOB: _______________________________ Sex: __________

Billing address:

____

(Street address) *(City)* *(State & Zip)*

Home phone #:_____________________________ **Cell phone #**:_______________________________________

Email address (for notifications and Patient Portal): ____

Primary language(s): ____

Primary care provider (Please select <u>one</u> provider):

□ Ana Paula Machado, MD □ Joan Magner, MD □ Robert Golenbock, MD □ Claire Bailey, MD □ Poonam Bherwani, MD □ Nicholas Tzakas, MD □ Dayna Nethercott, PA □ Lisa Boule, APRN □ Alpha Journal, PA □ Ashlee Mattutini, APRN

Please select a primary location: □ Danbury □ New Fairfield

Please complete both sides of Patient Registration Form.

Parent #1:

Last name:_______________________________ **First name**: _______________________**DOB**:_____________

Relationship to patient: ______________________ **Lives w/ patient?:** *Yes / No* / Other*

Cell phone: ___ __________**Work phone**:_________ __________

Employer: __________________________________ **Occupation:** ____________________________________

Parent #2:

Last name:___________________________ **First name**: ____________________**DOB**:_____________

Relationship to patient: ______________________ **Lives w/ patient?:** *Yes / No* / Other*

Cell phone: ___ __________**Work phone**:_________ __________

Employer: __________________________________ **Occupation:** ____________________________________

Parents are: □ Married □ Living Together □ Separated □ Divorced (If divorced, who is the Custodial Parent: □#1 □#2) □ Single □ Widowed

*(*Parent not living with patient address:* □#1 □#2)

____

(Street address) *(City)* *(State & Zip)*

Primary insurance: ______________________________**ID#:**____

Group#:_________________**Policy holder's full name**: _____________________________**DOB**:___________

Secondary insurance: _____________________________*ID#:*____

Group#:_________________*Policy holder's full name*: _____________________________*DOB*:___________

Emergency contact (**other than parent**):

Name:____________________________ *Phone#*:_____________________*Relationship* ___

Ethnicity (circle only one): Hispanic or Latino? *Yes / No / Decline to answer*
Race (circle all that apply): *American Indian or Alaskan Native / Asian / Black / Hawaiian or Pacific Islander / White / Decline to answer*

I have been provided with a copy of, read, and understand the financial policy of the Center for Pediatric Medicine and I agree to be bound by its terms. I also understand and agree that such terms will remain in force for the duration of my relationship with the Center for Pediatric Medicine and that such terms may be amended from time-to-time by the practice.

____ ____________________

Signature of patient or responsible party Date

Please complete both sides of Patient Registration Form.