Pediatric Specialists of Foxborough & Wrentham

Patient Registration Form ~ Please Complete **ALL** Information

Patient(s)

Name(s)	Date of Birth	M/F	Physician's Name
____________________	__________	___	______________
____________________	__________	___	______________
____________________	__________	___	______________
____________________	__________	___	______________
____________________	__________	___	______________
____________________	__________	___	______________

Primary Language: ______________ Race: __________ Ethnicity: __________

Address: ____

City: ______________________ State: ______ Zip Code: ____________

Parent(s) or Guardian(s)

Name: ________________ Male / Female

__ Financially Responsible DOB: __________

Address: ____________________

City: __________ State: ____ Zip Code: ______

(If Different)

Name: ________________ Male / Female

__ Financially Responsible DOB: __________

Address: ____________________

City: __________ State: ____ Zip Code: ______

Primary Phone Number: ________________ [ ] Land Line Number [ ] Cell Number

Secondary Phone Number: ________________

Tertiary Phone Number: ________________

Primary E-Mail Address: ________________

Patient 18 Years or Older:

Cell Phone Number ________________ E-Mail ________________

Insurance Information

Primary Health Insurance: ________________ Policy # ________________

Subscriber: ________________ Relationship to Patient: __________

Subscriber's Address: ________________ Subscriber DOB: ________

Secondary Health Insurance: ________________ Policy # ________________

Subscriber: ________________ Relationship to Patient: __________

Subscriber's Address: ________________ Subscriber DOB: ________

I authorize payment of medical benefits to the physician or supplier of Pediatric Specialists of Foxborough & Wrentham for services rendered during my child(ren)'s exam or treatment. I also authorize my child(ren)'s physician to release any information acquired in the course of their exam and/or treatment to my insurance company to determine these benefits or the benefits payable for related service. **If for whatever reason, my insurance does not pay for visits, I will be responsible to make payments.**

Sign: ________________ Print: ________________ Date: ____________

Completed by: ☐ Patient ☐ Parent/Guardian ☐ Other (Please Specify) ________________