Williamstown Pediatric Practice PA

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PATIENT REGISTRATION

Name _____ **Date of Birth**_____

Address _____ **City, State, ZIP** _____

Emergency Contact _____ **Phone** _____

Race _____ **Ethnicity** _____ **Language** _____

Parent Information

Father's Name _____ **Date of Birth** _____

Address _____ **Phone** _____

E-Mail Address _____ **Cell #** _____

Mother's Name _____ **Date of Birth** _____

Address _____ **Phone** _____

E-Mail Address _____ _____**Cell #** _____

Pharmacy's Name & Address ____ _____

Insurance & Billing Information

Insurance Company _____ **ID#** _____

Subscriber Name _____ **Date of Birth** _____

Insurance Company _____ **ID#** _____

Subscriber Name _____ **Date of Birth** _____

Assignment of Benefits

I Hereby authorize direct payment of medical benefits to Williamstown Pediatric, PA for services rendered. I understand that I am financially responsible for any balance not covered by my insurance including out of network benefits. I hereby authorize Williamstown Pediatric Practice to release information that may be necessary for medical care or processing applications for financial benefits.

Parent/Guardian _____ **Signature** _____ **Date**_____

Does the family have any of the following: Religious, culture, visual, language, or hearing barriers that would interfere with treatment? Yes/No
If yes please explain _____