MAIN STREET PEDIATRICS
Patient Registration

Patient Name: _____date of birth_____
Sex_____
Marital Status: NA
Patient SS#: _____
Patient Address:_____
_____

Patient home phone:_____

Name of Subscriber (parent) on insurance policy:_____
Sex_____
Subscriber date of birth:_____
Subscriber SS#:_____
Subscriber Employer_____
Employer Address: _____
_____

Work phone:_____
Cell phone:_____

All of the above information is REQUIRED by the state of Massachusetts in order to bill your medical claims. Thank you for your time and cooperation.

Emergency Contact:_____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM OR FOR FURTHER TREATMENT BY SPECIALISTS OR OTHER MEDICAL FACILITIES AS REQUIRED BY THE DOCTOR.

_____ _____
Patient/Legal Guardian Signature date

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PHYSICIAN.

_____ _____
Patient/Legal Guardian Signature date

Date completed: _____

PLEASE MAKE SURE FRONT OFFICE STAFF HAS A COPY OF YOUR INSURANCE CARD.