

Wayne Pediatric Associates

New Patient Registration

Family name _____

PLEASE PRINT

Children

Names

Dates of birth

/ /

/ /

/ /

/ /

/ /

Primary
Address

Apt # _____

City _____

State _____

Zip _____

Home Telephone _____

-

-

PLEASE INFORM US OF ANY OTHER ADDRESS
WE SHOULD HAVE ON FILE

Mother

Name _____

Date of birth

/ /

Cellphone _____

-

-

Work phone _____

-

-

Email _____

@

Send Practice emails?

Father

Name _____

Date of birth

/ /

Cellphone _____

-

-

Work phone _____

-

-

Email _____

@

Send Practice emails?

Insurance

Who is the primary insured?

Mother

Father

PLEASE PROVIDE YOUR CHILD(REN)'S INSURANCE CARD(S) FOR US TO PHOTOCOPY, OR COMPLETE BELOW...

Insurance Co. _____

ID # _____

Preferred pharmacy:

Name _____

Location _____

How did you hear about us?

Website

Obstetrician

Friend

In the event that my designated insurance plan does not pay for any medical services my family receives from Wayne Pediatric Associates, I understand that I will be personally responsible for such charges. I will notify Wayne Pediatric Associates promptly of any change to my medical insurance coverage so that it can submit accurate and timely insurance claims, and will be responsible for any charges resulting from my failure to do so.

Signature _____

Print Name _____

Date

/ /