BROCKTON PEDIATRICS, INC. 65 LIBBY STREET BROCKTON MA 02302 PHONE (508)-584-6060 FAX (508) 584-4949

PATIENT REGISTRATION FORM

LAST, FIRST, MIDDLE	
BIRTH DATE	GENDER
SOCIAL SECURITY #	
ADDRESS	
CITY- ZIP CODE	
HOME PHONE	
CELL PHONE	
WORK PHONE	
EMAIL ADDRESS	
PREFERRED PROVIDER	Dr. Kay __ Dr. Reno __ Dr. Pena __ Dr. Slosberg __ Maryanne Ladd PNP__ No Request __

	PRIMARY INS INFORMATION	**SECONDARY INS INFORMATION**
INSURANCE NAME		
INSURANCE ID#		
SUBSCRIBER/INSUREDNAME		
SUBSCRIBER/INSURED DOB		
SUBSCRIBER/INSURED SS#		
SUBSCRIBER RELATIONSHIP		
EMPLOYER: ADDRESS/PHONE		

EMERGENCY CONTACT NAME	
EMERGENCY CONTACT PHONE	
PERSON (S) AUTHORIZED TO SEEK TREATMENT	

GUARDIAN/PARENT INFORMATION

MOTHER'S NAME	
MOTHER'S DOB	
MOTHER'S SS#	
MOTHER'S ADDRESS/PHONE #	
FATHER'S NAME	
FATHER'S DOB	
FATHER'S SS#	
FATHER'S ADDRESS/PHONE#	

RACE/ETHNICITY/LANGUAGE

RACE	( ) ASIAN ( ) BLACK OR AFRICAN AMERICAN ( ) CAUCASIAN – WHITE ( ) OTHER (SPECIFY) _____	( ) NATIVE HAWAIIAN ( ) PACIFIC ISLANDER ( ) HISPANIC
ETHNICITY	( ) AMERICAN ( ) ARAB AMERICAN ( ) AFRICAN AMERICAN ( ) ASIAN AMERICAN ( ) JEWISH AMERICAN ( ) OTHER (SPECIFY)_____	( ) MEXICAN AMERICAN ( ) NATIVE AMERICAN ( ) NOT HISPANIC OR LATINO ( ) UNKNOWN
LANGUAGE	( ) ENGLISH ( ) SPANISH ( ) FRENCH ( ) PORTUGUESE	( ) CHINESE ( ) VIETNAMESE ( ) CREOLE

	( ) OTHER (SPECIFY)_____

*******PLEASE READ AND SIGN ON BACK OF THIS FORM*******

BROCKTON PEDIATRICS, INC.

PATIENT FINANCIAL RESPONSIBILITY DISCLOSURE STATEMENT
Your signature below forms a binding agreement between Brockton Pediatrics, Inc. (the provider of medical services) and the Patient who is receiving medical services or the Responsible Party for eligible dependents. The Responsible Party is the individual who is financially responsible for payment of medical bills.

MEDICAL INSURANCE. We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.
The person signing on behalf of the patient as the Responsible Party should:
* Inform Brockton Pediatrics of the current address, phone number and birth date of the patient and the responsible party.

* Present all current insurance cards prior to each office visit.

* Pay any required co- pay at the time of the visit.

- Pay any additional amount owing within 30 days of receiving a statement from our office. (When Brockton Pediatrics receives an
- explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you)

Returned Check Policy
If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to $20.00 Service Charge once notice is received of returned check. Brockton Pediatrics will send out a bill to responsible party, If payment is not made within a moderate time frame the account may be turned over to our collection agency.

Non-Payment on Account
Should collection proceedings or other legal action become necessary to collect an overdue account, the Patient or the patient's Responsible Party, understands that Brockton Pediatrics has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. Any collections costs or fees incurred will be charged to the responsible party. NON payment may have a negative impact on your credit report.
By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the Responsible Party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please Print) _____

Responsible Party Name (Please Print) _____

Responsible Party Signature_____

Date_____