Quincy Pediatric Associates Inc
Registration Form

(Please print clearly)

Today's Date:			PCP:		
Childs Last Name	First	Middle	M	F	Date of Birth
Mother's Name	Father's Name		Marital Status (circle one) Single/Mar/Div/Sep/Wid		
Street Address		Home Phone	Cell Phone	Email Address	
PO BOX	City	State	Zip Code		
Other family members seen here:					

GUARANTOR (person responsible for the bill)

Name	Date of Birth	Address if different	Cell phone

INSURANCE INFORMATION

Please indicate Primary Insurance		□Blue Shield	□HPHC	□Tufts Health	□United Health
□ Cigna Health	□ Aetna	□ Tricare	□ Masshealth	□ NHP	□ BMC
□ Network Health	□ Unicare	□ CMSP	□ Other-Please list		
Subscribers Name	Subscribers SS#	Date of Birth	Policy Number	Group Number	Copayment
Patients relationship to subscriber	□ Self	□ Spouse	□ Child	□ Other	
Secondary Insurance (if applicable)	Subscribers Name	Date of Birth	Policy Number		
Patients relationship to scriber	□ Self	□ Spouse	□ Child	□ Other	

IN CASE OF EMERGENCY

Name of friend or relative (not living at the same address)	Relationship	Home Phone	Cell phone

AUTHORIZATION

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid Directly to the physician. I understand that I am financially responsible for any balance, as stated in the financial policy, for which I received a copy. I also authorize Quincy Pediatric Associates Inc. or insurance company to release any information required to process my claims

_____ _____

Patient/Parent/Guardian Date