Children's Medical Group of Greenwich, affiliated with

Boston Children's Health Physicians
Until every child is well™
formerly CWPW

BCHP REGISTRATION

DATE: _____

PATIENT NAME: _____ MED REC NUMBER: _____

PATIENT ADDRESS:_____

DATE OF BIRTH: _____ AGE: _____ GENDER: _____

RESPONSIBLE PARTY/GUARDIAN:

NAME: _____ RELATIONSHIP: _____ PHONE NUMBERS:

MAILING ADDRESS: _____ HOME #:_____

_____ CELL #: _____

WORK #: _____

PARENT/GUARANTOR: FATHER'S NAME: _____

GUARANTOR PHONE #:_____

MOTHER'S NAME: _____

GUARANTOR ADDRESS: _____ EMPLOYER NAME _____

_____ ADDRESS: _____

PARENT EMAIL ADDRESS: _____

EMERGENCY CONTACT INFO:

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: _____

INSURANCE INFORMATION:

PRIMARY INS NAME & ADDRESS: ID #_____GROUP #_____

NAME: _____ CARDHOLDER: _____ EFF DATE: _____

ADDRESS: _____ CARDHOLDER DOB: _____ SEX: _____

_____

PRIM INS TEL #:_____

SECONDARY INS NAME & ADDRESS: ID #_____GROUP #_____

NAME: _____ CARDHOLDER: _____ EFF DATE: _____

ADDRESS: _____ CARDHOLDER DOB: _____ SEX: _____

_____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize BCHP to release information concerning treatment or services rendered to Medicare/other insurance carriers responsible for my or my dependent's care. I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to BCHP for any services rendered. I have been advised that if my insurance requires a co-pay it is due at the time of the visit. Otherwise, a $15 surcharge will be added to my bill.

Signature of Patient: _____ Date: _____