Kathleen Ennabi Pediatrics
Boston Children's Health Physicians
Until every child is well™

NEW PATIENT REGISTRATION

DATE: ____________________

PATIENT NAME: ________________________________ DATE OF BIRTH: ___/___/______

PHARMACY NAME: ____________________ PHARMACY ADDRESS: ____________________________

PATIENT RESIDES WITH: ____________________________ AGE: ________ GENDER: __________

RESPONSIBLE PARTY/GUARDIAN: ________________________ RELATIONSHIP: ________________

MAILING ADDRESS: ________________________________ HOME PHONE: ________________

________________________________ CELL PHONE: ________________

WORK PHONE: ________________

PARENT/GUARANTOR #1: ________________________________ PHONE: ________________

ADDRESS: ________________________________ EMAIL: ________________

____

EMPLOYER: ____________________ EMPLOYER ADDRESS: ____________________________

PARENT/GUARANTOR #2: ________________________________ PHONE: ________________

ADDRESS: ________________________________ EMAIL: ________________

____

EMPLOYER: ____________________ EMPLOYER ADDRESS: ____________________________

EMERGENCY CONTACT NAME: ________________________ RELATIONSHIP: ________________

PHONE NUMBER: ________________________

PRIMARY INSURANCE: ________________________________ ID #: ________________

INS. ADDRESS: ____________________________ CARDHOLDER: ________________

____________________________ CARDHOLDER DOB: __________ SEX: ________

INS. TELEPHONE #: ____________________________ EFFECTIVE DATE: ________________

SECONDARY INSURANCE: ________________________________ ID #: ________________

INS. ADDRESS: ____________________________ CARDHOLDER: ________________

____________________________ CARDHOLDER DOB: __________ SEX: ________

INS. TELEPHONE #: ____________________________ EFFECTIVE DATE: ________________

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Kathleen Ennabi Pediatrics / 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 $25 surcharge will be added to my bill.

Signature of Patient: ________________________________ Date: ____________________

Created by Ellen Nolan 12/30/10; edited by Lauren Coluccio 5/6/2016