Andover Pediatrics New Patient Registration Form

Please fill out <u>one</u> form for all children residing in the same home who have the same insurance

Today's Date:_____

Patient First & Last Name	DOB

Address:_____

Phone Number:_____ Email:_____

Parent/Guardian #1

Name:_____ DOB:_____

Address:_____

Phone Number:_____ Email:_____

Parent/Guardian #2 (if applicable)

Name:_____ DOB:_____

Address:_____

Phone Number:_____ Email:_____

Who lives at home with the children?_____

Do both Parent/Guardian listed above live in the home with the children:_____

PRIMARY INSURANCE	DO YOU HAVE SECONDARY INSURANCE?
INS. CO. NAME:	☐ **YES** ☐ **NO**
ID#:	INS. CO. NAME:
SUBSCRIBER NAME:	ID#:
SUBSCRIBER DOB:	SUBSCRIBER NAME:
EFFECTIVE DATE:	SUBSCRIBER DOB:
	EFFECTIVE DATE:

I acknowledge the information provided above is accurate. I understand that Andover Pediatrics is not responsible if incorrect information was provided. If this is a newborn visit and your child has not been added to your insurance, we will give you a separate form with directions on how to add them to your policy. You have 30 days to add your child to your insurance otherwise you will be self-pay.

Printed name of person filling out this form:_____

Signature:_____ **Date:**_____