Patient Registration

323 Riverside Avenue • Westport, CT 06880 • (203)221-7337

Account # _____
Date _____ / _____ / _____

Mother/Father/Guardian _____ DOB _____ / _____ / _____ SS # _____
Address _____ Occupation _____
City/State/Zip _____ Home Phone _____ Cell Phone _____
Employer _____ Work Phone _____ Email _____
Employer Address _____

Mother/Father/Guardian _____ DOB _____ / _____ / _____ SS # _____
Address _____ Occupation _____
City/State/Zip _____ Home Phone _____ Cell Phone _____
Employer _____ Work Phone _____ Email _____
Employer Address _____

Child _____ Sex: ○ M ○ F DOB _____ Child _____ Sex: ○ M ○ F DOB _____
Child _____ Sex: ○ M ○ F DOB _____ Child _____ Sex: ○ M ○ F DOB _____
Child _____ Sex: ○ M ○ F DOB _____ Child _____ Sex: ○ M ○ F DOB _____

Emergency contact person _____ Email _____
Relationship _____ Home Phone _____ Cell Phone _____
Preferred pharmacy _____ Address _____ Phone _____

Names, relationship, and cell phone numbers of individuals (other than parents) who might be bringing children in for visits.
* Note: The person bringing in the child is responsible for payment.

Name	Cell Phone	Name	Cell Phone

Who may we thank for referring you to us? _____

Party responsible for payment of medical services: ○ Mother ○ Father ○ Both Parents ○ Guardian

Insurance Information (you must provide us with a copy of your current insurance card)
Insurance Company _____ I.D. _____ Effective Date _____ Co-Pay $_____
Insurance provided through: ○ Employer ○ Private ○ Other ○ Self Pay Name of Insured
Name and full address of Employer _____
Note: You need to select one of our physicians as your primary care physician and notify your insurance of selection.
Please indicate name of physician shown on your card _____

Authorization of Treatment and Assignment of Benefits:
I authorize Village Pediatrics, to treat my child/children. I further authorize the release of medical information necessary for the completion of insurance forms, school & camp forms. I authorize payment directly to Village Pediatrics, for any and all medical or surgical benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse Village Pediatrics for any payments my insurance company may have sent to me in error. I understand that I am financially responsible for all co-payments and any charges not covered under my insurance benefits. I also understand that I am responsible for advising Village Pediatrics of any and all changes to my insurance. Co-payments are due on date of service. Failure to do so will result in an additional billing charge of $25.00. Our office requires 24 hours notice of appointment cancellation. Failure to provide this notice will incur a cancellation fee. Village Pediatrics requires a credit card on file. If there is an outstanding balance we will contact you to see if you would like it placed on your credit card or if you would like to pay by another method.

Signature _____ Relationship _____ Date _____
A photocopy of this authorization shall be considered as effective and valid as the original.