

****** PLEASE PROVIDE INSURANCE CARD TO RECEPTIONIST ******

Please Print: **Primary Care Physician** _____

Patient Last Name _____ Patient First Name _____

Address _____ Phone Number _____

City / Zip _____ Cell Phone _____

Date of birth _____ Sex _____

Parents / Legal Guardian

Mothers Full Name _____ Date of birth _____

Fathers Full Name _____ Date of birth _____

Primary Insurance

Insurance _____

Patient ID# _____ // **Group #** _____

Subscriber (person who carries the insurance) _____

Subscribers Employer _____

Secondary Insurance (if any)

Insurance _____

Patient ID# _____ // **Group #** _____

Subscriber (person who carries the insurance) _____

Subscribers Employer _____

Pharmacy Name & Telephone Number _____

Contact in case of emergency _____
(other than listed above) Relationship to patient phone number

**PLEASE SIGN AND DATE THE SECOND PAGE AND RETURN BOTH PAGES
TO RECEPTIONIST**

Date _____

I AUTHORIZE WALPOLE PEDIATRIC ASSOCIATES TO RELEASE THE INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS SO THAT PAYMENTS MAY BE MADE ON MY BEHALF FOR SERVICES PROVIDED TO MY FAMILY. I AGREE TO MAKE MY CO-PAYMENTS AT THE TIME OF MY VISIT AND ACKNOWLEDGE THAT THIS IS A REQUIREMENT OF MY INSURANCE CARRIER. I AUTHORIZE PAYMENT OF BENEFITS TO THE FOLLOWING:

WALPOLE PEDIATRIC ASSOCIATES
MICHAEL A. FREIBERGER, MD
PETER B. COHN, MD
NEAL R. PATEL, MD
DENISE R. SHIU, MD
RACHEL A. LEVENSON-ACKER, MD
FRANCES A. ORLANDO, MD

I ACCEPT RESPONSIBILITY FOR PAYMENT TO WALPOLE PEDIATRICS FOR OFFICE VISITS IF PAYMENT IS NOT ISSUED BY MY INSURANCE CARRIER, FOR THE FOLLOWING, BUT NOT LIMITED TO, REASONS:

NON-COVERED SERVICES BY MY INSURANCE COMPANY
NO CURRENT ACTIVE INSURANCE
CO-INSURANCE RESPONSIBILITIES
DEDUCTIBLE RESPONSIBILITIES

Please list the names of additional family members:

Signature _____

Relationship to child _____