Washington Pediatric Associates, PC
Patient Registration

Welcome to our office. In order to serve you properly, we will need the following information. (Please Print)
All information will be kept strictly confidential.

Patient's Name: Sex: M F Date of Birth:

Address: Phone:

Mother/Guardian Name: Phone: Home:
Address: Work:
Cell Phone:

Occupation:
Employer's Name/Address:

Father/Guardian Name: Phone: Home
Address: Work:
Cell Phone:

Occupation:
Employer's Name/Address:

Financially Responsible Person: Relationship to Patient:
Address: Date of Birth:
Phone: SS#:

Primary Health Insurance Name: Effective Date of Insurance Coverage:
Policy #: Group #:
Policy Holder's Name: Policy Holder's Date of Birth:
Mailing Address for Claims: Phone:

Secondary Health Insurance Name: Effective Date of Insurance Coverage:
Policy #: Group #:
Policy Holder's Name: Policy Holder's Date of Birth:
Mailing Address for Claims: Phone:

Emergency Contact Name: Phone:
Relationship to Patient:

How did you hear about our practice?

Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Washington Pediatric Associates (WPA) for any services furnished to me by the physician and staff of WPA. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment, or supplies provided. This information will be used for the purpose of evaluating and administering claims of benefits.

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Patient, Parent, or Guardian Signature (if child is under 18-years-old) Date