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

Registration Form

PATIENT			
First Name:	Last:	DOB: / /	M / F
Current Address:			
City:	State:	Zip:	

ADDITIONAL PATIENTS (if any)			
1. First Name:	Last:	DOB: / /	M / F
2. First Name:	Last:	DOB: / /	M / F
3. First Name:	Last:	DOB: / /	M / F
4. First Name:	Last:	DOB: / /	M / F

PARENT/GUARDIAN 1				
First Name:	Last:	(Maiden:	) DOB: / /	M / F
Home Phone:		Cell Phone:		
Email Address:				
Current Address (if different from above):				
City:		State:	Zip:	

PARENT/GUARDIAN 2				
First Name:	Last:	(Maiden:	) DOB: / /	M / F
Home Phone:		Cell Phone:		
Email Address:				
Current Address (if different from above):				
City:		State:	Zip:	

EMERGENCY CONTACT		
Select one: ☐ Parent/Guardian 1 ☐ Parent/Guardian 2 ☐ Other (If Other, please complete below)		
First Name:	Last:	M / F
Relationship to Patient:	Contact Phone:	

GUARANTOR (Person responsible for copayments, deductibles, and non-covered expenses)			
Select one: ☐ Parent/Guardian 1 ☐ Parent/Guardian 2 ☐ Other (If Other, please complete below)			
First Name:	Last:	DOB: / /	M / F
Relationship to Patient:	Contact Phone:		
Current Address (if different from above):			
City:	State:	Zip:	

PRIMARY INSURANCE			
Policy Holder's Name:		DOB: / /	M / F
Current Address (if different from above):			
City:	State:	Zip:	
Employer's Name:	Work Phone:		
Insurance Name:	Phone:		
Insurance ID:	Group #:	Effective Date: / /	
***__If you are an existing patient and this is a new insurance policy, please indicate the following:__			
Previous Insurance Name:		Termination Date: / /	

SECONDARY INSURANCE (if any)			
Policy Holder's Name:		DOB: / /	M / F
Current Address (if different from above):			
City:	State:	Zip:	
Employer's Name:	Work Phone:		
Insurance Name:	Phone:		
Insurance ID:	Group #:	Effective Date: / /	

I hereby authorize BCHP to release information concerning treatment or services rendered to my insurance carriers who are responsible for my/my dependent's care. I request payment of authorized medical benefits to be made directly to BCHP for services rendered to me/my dependent. I have been advised that co-payments not paid at the time of service will be subject to a $15 surcharge. I understand that I am responsible for any amount determined to be my liability to the provider, including deductibles, co-payments, and non-covered services.

X_____ Date: ___/___/___

Parent/Guardian Signature