



Westwood Office
 541 High Street
 Westwood, MA 02090
 (781) 326-7700
 Fax (781) 251-0910

Mansfield Office
 454 Chauncy Street
 Mansfield, MA 02048
 (508) 339-9944
 Fax (508) 452-3898

Easton Office
 115 Main Street
 Easton, MA 02356
 (508) 535-5535
 Fax (508) 238-1315

www.wmpeds.com

Patient Registration Form

Patient Information:

Last Name: _____ First Name: _____ Middle Initial: _____
 Date of Birth: _____ Sex: Male | Female
 Address: _____ Apt/Unit: _____
 City: _____ State: _____ Zip Code: _____
 Race: _____ Ethnicity: _____ Language: _____
 Primary Care Physician: _____
 _____ (circle one) _____ (circle one)
 Home Phone #: _____ Can Message Be Left: Y N Message Type: Brief Extended
 Cell Phone #: _____ Can Message Be Left: Y N Message Type: Brief Extended
 Can We Text you? Y N
 E-Mail Address: _____
 Parent #1 Name: _____ Parent #2 Name: _____

Person Responsible for Bill:

Last Name: _____ First Name: _____ Middle Initial: _____
 Date of Birth: _____ Relation: _____
 Address: _____ Apt/Unit: _____
 City: _____ State: _____ Zip Code: _____
 Home Phone: _____ Cell Phone: _____

Medical Insurance Information: (copy of insurance card required to file insurance)

Policy Holder: Last Name: _____ First Name: _____
 Insurance Name: _____
 Certificate # _____ Group # _____ Member # _____

Other Children:

Last Name: _____ First Name: _____ Middle Initial: _____
 Date of Birth: _____ Sex: Male | Female
 Last Name: _____ First Name: _____ Middle Initial: _____
 Date of Birth: _____ Sex: Male | Female
 Last Name: _____ First Name: _____ Middle Initial: _____
 Date of Birth: _____ Sex: Male | Female
 Last Name: _____ First Name: _____ Middle Initial: _____
 Date of Birth: _____ Sex: Male | Female

How did you hear of us? (circle one) Family/friend | Web search | Social media | Print advertisement | Other

Assignment of Benefits and Release of Information:

I hereby authorize my insurance benefits to be paid to Westwood-Mansfield Pediatric Associates and acknowledge that I am responsible for any balance not covered by those benefits. I authorize Westwood-Mansfield Pediatric Associates to release information requested concerning my care to insurers paying such benefits.

Signature: _____ Date: _____

9/2015

