OCEAN STATE PEDIATRICS, INC.
Pediatric & Adolescent Medicine
1672 South County Trail
East Greenwich, Rhode Island 02818
PH: (401) 886-7881 FX: (401) 886-7883

PATIENT REGISTRATION FORM

PATIENT NAME: _____ DATE: _____

ADDRESS: _____ M ___ F ___

CITY: _____ PHARMACY NAME: _____

STATE: _____ ZIP: _____ PHARMACY #: _____

DATE OF BIRTH: _____ HOME PHONE #: _____

REFERRED BY: _____ CELL PHONE #: _____

MOTHER'S NAME: _____ DATE OF BIRTH: _____

MOTHER'S EMPLOYER: _____ OCCUPATION: _____

WORK PHONE #: _____ EMAIL ADDRESS: _____

FATHER'S NAME: _____ DATE OF BIRTH: _____

FATHER'S EMPLOYER: _____ OCCUPATION: _____

WORK PHONE #: _____ Race: ☐ Caucasian ☐ African American ☐ Hispanic
☐ Native American ☐ Alaska Native

CHILD'S PRIMARY INSURANCE PLAN: _____

CLAIM'S ADDRESS: _____

INSURANCE I.D. #: _____

GROUP POLICY #: _____

SUBSCRIBER'S NAME: _____ DATE OF BIRTH: _____

CHILD'S SECONDARY INSURANCE PLAN: _____

CLAIM'S ADDRESS: _____

INSURANCE I.D. #: _____ GROUP POLICY #: _____

SUBSCRIBER'S NAME: _____ DATE OF BIRTH: _____

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of medical benefits to ***Ocean State Pediatrics, Inc.*** for services rendered in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

I hereby authorize (please circle) **Dr. Zinck / Dr. Noel / Dr. Silversmith / Dr. Haines / Dr. Willis / Dr. First** to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

A photocopy of these assignments shall be valid as the original.

Parent / Guardian (please print): _____
(person financially responsible for patient balance)

Signature: _____ Date: _____

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