LYNNFIELD PEDIATRICS
628 Salem Street
Lynnfield MA 01945
781-599-1998
www.lynnfieldpediatrics.com

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name	First	MI	Female( ) Male ( )	Birth Date	Home Phone #
Address	Apt #	City	State		Zip
Do any other family member(s) come to this office?		Yes ( )	No ( )		Patient Cell Phone #
Names / ages of all children in household					
Emergency Contact other than parent(s)/guardian (name & #)					

PARENT/GUARDIAN #1

Last Name	First	MI	Female ( ) Male ( )	Home Phone #	Birth Date
Address	Apt #	City	State		Zip
S.S #	Employer				Marital Status
Work #	Cell Phone #	E-Mail			

PARENT/GUARDIAN #2

Last Name	First	MI	Female ( ) Male ( )	Home Phone #	Birth Date
Address	Apt #	City	State		Zip
S.S #	Employer				Marital Status
Work #	Cell Phone #	E-Mail			

INSURANCE

Primary Insurance – Name & Address			
Policy #	Group #	Effective Date	Relationship to patient
Policy Holder Name		DOB	SS#
Secondary Insurance – Name & Address			
Policy #	Group #	Effective Date	Relationship to patient

I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF (FOR MEDICAL SERVICES PROVIDED) TO: LYNNFIELD PEDIATRICS. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS FOR MEDICAL BENEFITS. I HAVE BEEN ADVISEDOF THE *FINANCIAL POLICY AND PRIVACY POLICY OF LYNNFIELD PEDIATRICS.*

Signature of Patient/Parent/Legal guardian _____ Date _____
