Affiliated with

CHILDREN'S & WOMEN'S PHYSICIANS OF WESTCHESTER, LLP

CWPW REGISTRATION

DATE: _____

PATIENT NAME: _____ **MED REC NUMBER:** _____

PATIENT ADDRESS:_____

DATE OF BIRTH: _____ **AGE:** _____ **GENDER:** _____

RESPONSIBLE PARTY/GUARDIAN:

NAME: _____ **RELATIONSHIP:** _____ **PHONE NUMBERS:** _____

MAILING ADDRESS: _____ **HOME #:**_____

_____ **CELL #:** _____

WORK #: _____

PARENT/GUARANTOR: **FATHER'S NAME:** _____

GUARANTOR PHONE #:_____

MOTHER'S NAME: _____

GUARANTOR ADDRESS: _____ **EMPLOYER NAME** _____

_____ **ADDRESS:** _____

EMERGENCY CONTACT INFO:

EMERGENCY CONTACT NAME: _____ **RELATIONSHIP:** _____

PHONE NUMBER: _____

INSURANCE INFORMATION:

PRIMARY INS NAME & ADDRESS: **ID #**_____**GROUP #**_____

NAME: _____ **CARDHOLDER:** _____ **EFF DATE:** _____

ADDRESS: _____ **CARDHOLDER DOB:** _____ **SEX:** _____

_____

PRIM INS TEL #:_____ **PARENT SOCIAL SECURITY NUMBER** _____

SECONDARY INS NAME & ADDRESS: **ID #**_____**GROUP #**_____

NAME: _____ **CARDHOLDER:** _____ **EFF DATE:** _____

ADDRESS: _____ **CARDHOLDER DOB:** _____ **SEX:** _____

_____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize CWPW to release information concerning treatment or services rendered to Medicare/other insurance carriers responsible for my or my dependent's care. I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to CWPW for any services rendered. I have been advised that if my insurance requires a co-pay it is due at the time of the visit. Otherwise, a $20 surcharge will be added to my bill.

Signature of Parent/Guardian: _____ Date: _____