

**Pediatric Advanced Care of West Haven, LLC  
Patient Registration Form – Online Submission**

**\*PATIENT INFORMATION**

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex:

M \_\_\_\_\_ F \_\_\_\_\_

Soc. Security # \_\_\_\_\_ **CELL PHONE:**

\_\_\_\_\_ Home: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

**EMAIL ADDRESS:** \_\_\_\_\_

Child's Nationality: \_\_\_\_\_

Primary Language spoken: \_\_\_\_\_

**DO YOU INTEND TO VACCINATE YOUR CHILD? Circle one: YES / NO (new patients only)**

How did you hear about our office? \_\_\_\_\_ (new patients only)

**\*In Case of Emergency, who should we contact?**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

**\*PHARMACY INFORMATION:**

Pharmacy Name: \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_

**\*INSURANCE INFORMATION: PLEASE PROVIDE COPY OF INSURANCE CARD**

Insurance Company: \_\_\_\_\_ Subscriber

ID# \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SS

# \_\_\_\_\_

**SECONDARY INSURANCE: (if applicable):**

Insurance Company: \_\_\_\_\_

ID# \_\_\_\_\_

**\*PERSON RESPONSIBLE FOR ACCOUNT:**

Name: \_\_\_\_\_

Social Security# \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_

*I hereby authorize payment directly to Pediatric Advanced Care of West Haven for all insurance benefits otherwise payable to me for services rendered. I understand I am financially responsible for all charges, whether or not paid by Insurance, and for all services rendered on my behalf or my dependents.*

*I authorize the above provider in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. **I also give PAC permission to text me with appointment confirmation information and I realize that SMS charges may occur.***

**\*Signature of Responsible Party:** \_\_\_\_\_

**Date:** \_\_\_\_\_