READING PEDIATRICS
NEW PATIENT ENROLLMENT FORM

Please circle one: Child resides with 1) Both Parents 2) Father 3) Mother 4) Other

List full name and date of birth of all children:

1.______________________________
LAST FIRST DOB

2.______________________________
LAST FIRST DOB

3.______________________________
LAST FIRST DOB

4.______________________________
LAST FIRST DOB

ADDRESS: ______________________________
Street City State/Zip

HOME PHONE: (______) ______________ CELL PHONE: (______) ______________

FATHER'S NAME/DOB ______________ MOTHER'S NAME/DOB ______________

PREFERRED LANGUAGE: English ______ Spanish ______ Other ______
ETHNICITY: (Please check one) Hispanic or Latino ______ Not Hispanic or Latino ______
RACE: (Please check All that apply) American Indian or Alaska Native ______ Asian ______
Black or African American ______ White ______ Native Hawaiian or Pacific Islander ______

Does this apply for All children? YES or NO If no, please specify ______________

EMAIL: ______________ CONFIRM EMAIL: ______________

INSURANCE INFORMATION

PRIMARY INSURANCE ______________
NAME OF POLICY HOLDER ______________ DOB ______________
EMPLOYER ______________ EFFECTIVE DATE ______________

SECONDARY INSURANCE ______________
NAME OF POLICY HOLDER ______________ DOB ______________
EMPLOYER ______________ EFFECTIVE DATE ______________

If billing address is different than patient, please complete below:

NAME ______________ RELATIONSHIP ______________
ADDRESS ______________________________
STREET CITY STATE/ZIP

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize READING PEDIATRICS, INC. to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to READING PEDIATRICS,INC.

DATE ______________ SIGNATURE ______________
DATE ______________ RECEPTIONIST RECEIVING ENROLLMENT ______________