New Canaan PEDIATRICS
173 East Avenue, New Canaan, CT 06840

New Patient Registration

Today's Date_____

Parent/Guardian #1: Name _____Date of Birth_____

Parent/Guardian #2: Name_____ Date of Birth_____

Primary Email: _____

Address: Street Address_____

City_____State/Province_____Postal Code_____

Primary Cell # _____Home #_____

Please List Your Child's/Children's Names and Date of Birth:

Name DOB:

1._____ _____M/F Were your children ever patients here before? ☐ Yes ☐ No

2._____ _____M/F

3._____ _____M/F

4._____ _____M/F

Name of individual and relationship of person who has permission to bring in my child and be responsible for any directives given by NC Pediatrics.

Name:_____Cell #_____Home#_____

INSURANCE CARDS MUST BE PRESENTED AT EACH VISIT

All professional services rendered are billable to insurance. All efforts to bill claims to your insurance will be made. However, the guarantor is responsible for charges if correct insurance in not given within the timely filing limits as set forth by the individual's insurance company. All co-pays are due at time of service. Per the agreement with your insurance, you will be billed for coinsurance or deductible balances. Payment is due upon receipt of our statement unless alternate payment arrangements are made with our billing manager.

Insurance Authorization and Assignment

I request that payment authorized Medicare/Other Insurance Company benefits be made either to me or on my behalf to Connecticut Pediatric Partnership, LLC. For any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claim/Other Insurance Company claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown in Medicare/Other Insurance Company as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charged determination of the Medicare/Other Insurance Company.

Name of Insurance Company _____

Insurance ID# _____Insurance provided by employer: ☐ Yes ☐ No

How did you hear about us? _____