North Reading Pediatrics
21 Main St.
North Reading, MA 01864
(978) 664-4698

Registration Forms

Patient's Name____ D.O.B.___________________________

Home #_____________________ Cell # _______________________ Cell #________________________

Address____

If patient is a minor
Mother's Name_____________________________ Father's Name________________________________

Insurance Company________________________________ ID # __________________________________

Guarantor (Who holds the policy) ________________________________ D.O.B. ____________________

Guarantor's phone # _________________________Relationship to patient __________________________

Emergency Contact____________________________________ Phone # ____________________________

Relationship to patient ____

Previous Doctor ____________________________ Facility's Name_________________________________

Facility's Phone # ____

I do hereby authorize the treatment of my child and administration of medication and immunizations as required by the Commonwealth of Massachusetts and Academy of Pediatrics by the medical staff at North Reading Pediatrics. I also understand that my child may also receive treatments by other members of the professional staff according to their roles in this office, under the supervision of the medical staff. I authorize the release of my records to my Health Insurance Company. I authorize payment of medical benefits to the undersigned physician or provider for services. I authorize care of my child in my absence.

Signature of Patient (if 18 or older) or Parent/ Guardian

____ Date ____________

Rev.1/20/20