Patient Enrollment Data Form

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Children	1	2	3	4	5
First Name					
Middle Initial					
Last Name					
Date of Birth					
Gender					

Address: # & Street: _____

City/State: _____ Zip Code: _____

Parent's Names	#1	#2
Dates of Birth		
Home Phone		
Cell Phone		
Work Phone		
E-mail		

Guarantor/Subscriber (person who holds the insurance)

Full Name	
Date of Birth	
Address (if different)	
Insurance Company	
Plan Type – (Please Circle): HMO PPO EPO POS Commercial	
ID Number (specify for each child if different):	
Co-Pay for OV	

I hereby give permission to bill my insurance for all appropriate services.

Signature: _____ (print name) _____

I understand that I am liable for all charges not covered by my insurance, as well as, applicable co-payments and deductible balances. I accept responsibility for informing the office of any changes in insurance in a timely manner and will agree to pay any balances resulting from my failure to do so.

Signature: _____ date: _____

I consent to have the office share my child's vaccination records with MIIS (the MA state vaccine registry): Yes ____ No ___