Patient Registration Form

David Fredenburg, MD, PA
Pediatric & Adolescent Medicine
49 Derry Road (Route 102)
Hudson, NH 03051-4027

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Welcome to our office.

Please fill out this form as completely as possible. If you have any questions or need assistance in completing this form, please feel free to ask one of us.

Patient's Name: ____ Sex: ___ Birth date: ___________
First Middle Last

Address: ____
Street / Road City / Town Zip code

Preferred phone: (_____)_________________

Mother / Stepmother / Guardian Name: ____
Please circle appropriate relationship

Address: ____ Employer: ____________________

Home phone: (____)_____________ Work phone: (____)_____________ Cell phone: (____)_____________

Father / Stepfather / Guardian Name: ____
Please circle appropriate relationship

Address: ____ Employer: ____________________

Home phone: (____)_____________ Work phone: (____)_____________ Cell phone: (____)_____________

Siblings (please include siblings that are current patients at this office):

Full Name: ____ Birth date: ______________ Sex: _____
First Middle Last

Full Name: ____ Birth date: ______________ Sex: _____
First Middle Last

Full Name: ____ Birth date: ______________ Sex: _____
First Middle Last

Full Name: ____ Birth date: ______________ Sex: _____
First Middle Last

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Patient Name: ____ Birth date: ___________________

Primary Insurance
(Please provide a copy of the current insurance card) Effective date: _________________

Insurance company: ____ Phone #: (____)________________

Claims address: ____
Street / Road City / Town Zip code

Name of subscriber: ____ Social Security #: _______________

Subscriber birth date: _______________ Certificate / ID #: _____________________ Group #: ____________

Employer: ____

Other Insurance
(Please provide a copy of the current insurance card) Effective date: _________________

Insurance company: ____ Phone #: (____)________________

Claims address: ____
Street / Road City / Town Zip code

Name of subscriber: ____ Social Security #: _______________

Subscriber birth date: _______________ Certificate / ID #: _____________________ Group #: ____________

Employer: ____

Emergency Notification (please provide name & phone number for someone not living in the same house)

Name: ____ Phone: ______________________

How did you hear about this practice? ____

I have provided information about all current insurance coverage for this patient and will notify the office when any changes in coverage occur. I authorize David Fredenburg MD PA to submit to my insurance carrier claims for care provided and to release any medical information necessary to process the claim. I authorize payment of medical benefits to David Fredenburg MD PA for and services for which assignment is accepted. I understand that I may be responsible for payment of all office services at the time of the visit. I have also had an opportunity to review the Office Policies posted in the office or provided with this registration, and am aware of its contents.

Patient/Parent/Guardian name (please print): ____

Signature: ____ Date: ________________