chevy chase PEDIATRICS
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NEW PATIENT REGISTRATION FORM

TODAY'S DATE:

Parent 1: DOB Gender/Pronouns

Street Address City

State & Zip Email Address

Cell # Work #

Occupation Employer

Parent 2: DOB Gender/Pronouns

Street Address City

State & Zip Email Address

Cell # Work #

Occupation Employer

Financial Guarantor:
☐ Parent 1 ☐ Parent 2 ☐ Other: DOB Gender/Pronouns

Street Address (leave this section blank if Parent 1 or 2) City, State & Zip

Cell # Email

Primary Health Insurance:
☐ UHC ☐ Cigna ☐ Other:

Member ID Group #

Policy Holder's Name Policy Holder's DOB

Secondary Health Insurance Name: Policy # Group #

Emergency Contact: (other than parents) Contact Cell #

Child LAST NAME, FIRST NAME	**Date of Birth**	Gender/Pronouns	Cell Phone (if applicable)

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TO BE SIGNED AT YOUR FIRST OFFICE VISIT (disregard for now)

I, the undersigned, authorize payment of medical benefits to Chevy Chase Pediatric Center for any services provided to me by their physicians and staff. I understand that I am financially responsible for any amount not covered by my insurance. I also authorize you to release sensitive medical information including any advice, treatment, or supplies provided to my insurance company and their agents.

Signature: _____ Date: _____