Westside Pediatrics

The Family Registration Form

Date:_____

Please complete and bring with you to your first appointment along with your current insurance ID card.

Registering with:

☐ **Lawrence Kagan, MD** ☐ **Dorothy Klein, MD** ☐ **Emily Bruckner, MD** ☐ **Caitlin Colvard, MD** ☐ **Jessica Zak, MD**

First Time Parents • Due Date: _____ OB: _____Hospital: _____

Mother • Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone • Home: _____ Cell: _____ Email: _____

Father • Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone • Home: _____ Cell: _____ Email: _____

Parents are: ☐ Married ☐ Divorced ☐ Never Married ☐ Separated Widow(er)

Who has medical decision making authority? ☐ Mother ☐ Father ☐ Both ☐ Other

In case of emergency, notify (other than parents): Name:_____

Phone:_____ Relationship to patient: _____

Does your emergency contact have medical decision making authority? ☐ Yes ☐ No

Pharmacy • Name: _____ Phone: _____

Address: _____

Dr. Kagan and Dr. Klein are out of network providers. Payment in full is due at the time of each visit. As a courtesy to our clients, Westside Pediatrics will submit your insurance claim for you. We do not verify insurance coverage. Assuming the insurance information provided is accurate, you will receive reimbursement directly from your insurance carrier.

Dr. Bruckner, Dr. Colvard and Dr. Zak are in network providers. Please verify that she is in network for your health insurance policy. We do not bill secondary insurances. Payments are due based on your coverage. Patients are required to keep a credit card on file for balances that your insurance does not cover, but for which you are liable.

Please be sure to notify us of any changes in your insurance policy and remember to register your newborn within thirty days of birth. Westside Pediatrics will provide you with the necessary paperwork to assist you in your record keeping. Concerns can be diverted to the office manager at ckagan@wspeds.net.

Policy Holder: _____ Insurance Company: _____

Primary ID No: _____ Group ID No.: _____

Address: _____

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Family History (Have any family members had the following?):

Deafness	Yes____	No____	Relationship_____
Food Allergies	Yes____	No____	Relationship_____
Seasonal Allergies	Yes____	No____	Relationship_____
Asthma	Yes____	No____	Relationship_____
Eczema	Yes____	No____	Relationship_____
Psoriasis	Yes____	No____	Relationship_____
Hyper/Hypothyroidism	Yes____	No____	Relationship_____
Diabetes (before 50)	Yes____	No____	Relationship_____
Heart Disease (before 50)	Yes____	No____	Relationship_____
High Blood Pressure (before 50)	Yes____	No____	Relationship_____
High Cholesterol	Yes____	No____	Relationship_____
Bleeding Disorders	Yes____	No____	Relationship_____
Autism	Yes____	No____	Relationship_____
Learning/Attention Disorder	Yes____	No____	Relationship_____
Metabolic/Genetic Disorder	Yes____	No____	Relationship_____
Mental Illness	Yes____	No____	Relationship_____
Seizures/Epilepsy	Yes____	No____	Relationship_____
Cancer	Yes____	No____	Relationship_____
Immune Disorder	Yes____	No____	Relationship_____
Other	Yes____	No____	Relationship_____

Referred By: _____