Wakefield Pediatric Associates

15 Richardson Avenue, Wakefield, MA 01880
Telephone: (781) 245-2203 Fax: (781) 245-7303

PATIENT INFORMATION

Patient Name: _____

Patient Address: _____

City: _____ State:_____ Zip Code: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

PCP: ☐ Dr. Wang ☐ Jaime Lincoln, NP ☐ Andrea Jacobs, NP

Phone: _____ ☐ Home ☐Cell ☐Work Whose number? _____

Phone: _____ ☐ Home ☐Cell ☐Work Whose number? _____

Phone: _____ ☐ Home ☐Cell ☐Work Whose number? _____

Parent(s) or Guardian(s) Name & DOB: _____

Parent Email: _____ Preferred Language: _____

Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Other:_____

Race: ☐White ☐Black or African American ☐ Native Hawaiian ☐ Pacific Islander

☐ American Indian or Alaska Native ☐ Asian ☐Other _____

GUARENTOR INFORMATION

Guarantor's Name: _____ DOB: _____

Guarantor Address (If Different): _____

City: _____ State:_____ Zip Code: _____

PRIMARY INSURANCE INFORMATION

Insurance Name: _____

Policy Number: _____ Group/Plan Number: _____

Subscriber Party Name: _____ Subscriber DOB: _____

Subscriber Party Address (If Different): _____

City: _____ State:_____ Zip Code: _____

PHARMACY BENEFIT INSURANCE INFORMATION

Insurance Name:_____ ID: _____

RxBIN: _____ RxPCN: _____ RxGRP: _____

ASSIGNMENT OF BENEFITS STATEMENT

I authorize the release of medical information to process this claim and related claims. I authorize the payment of medical benefits directly to the provider of services. I understand that I am financially responsible for charges not covered by my insurance.

Date: _____ Signature: _____