Division of
Sports Medicine

Boston Children's Hospital

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

Affiliated Group Pre-Registration Form

What is the reason for the appointment? ____

Patient name: ____

DOB: ______________ Social Security #: ______________________ Sex: M F

Street address: ____________________ City: __________ State: _____ Zip: ______

Day phone: ______________________ Cell phone: ______________________

College/group: ______________________ Sport: ______________________

Primary Care Physician (full name): ______________________________

City: ______________________ State: _____ Office phone: ______________

** If your insurance company requires referrals, please contact your primary care physician prior to your appointment.*

Insurance company name: ______________________________________

Insurance ID: ______________________ Group #: ______________________

Insurance company address: ______________________________________

City: ______________ State: ______ Zip code: ________ Phone: ______________

Subscriber's name: ______________________ DOB: ______________

If the patient is under 18, who is the person financially responsible after insurance?

Name: ______________________________ DOB: ______________

Emergency Contact

Full Name: ____

Street address: ____________________ City: __________ State: _____ Zip: ______

Home phone: ______________________ Cell phone: ______________________

Please fax or e-mail completed Affiliate forms to Bethel Haile bethel.haile@childrens.harvard.edu
Fax: 617-730-0178; Phone: 857-218-5093 Office: 857-218-5090, NU: 617-373-5174, Pager: # 1679
Dance Affiliates to Darnell Hardmon darnell.hardmon@childrens.harvard.edu
Fax: 617-730-0178; Phone: 617-355-6884