

**Dr. Kathleen Ennabi, MD affiliated with  
CHILDREN'S & WOMEN'S PHYSICIANS OF WESTCHESTER, LLP**

**CWPW REGISTRATION**

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ GENDER: \_\_\_\_\_

PHARMACY: \_\_\_\_\_

**RESPONSIBLE PARTY/GUARDIAN:**

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE NUMBERS: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_ HOME #: \_\_\_\_\_

\_\_\_\_\_ CELL #: \_\_\_\_\_

WORK #: \_\_\_\_\_

PARENT/GUARANTOR: FATHER'S NAME: \_\_\_\_\_

GUARANTOR PHONE #: \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_

GUARANTOR ADDRESS: \_\_\_\_\_

**EMERGENCY CONTACT INFO:**

EMERGENCY CONTACT NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

**INSURANCE INFORMATION:**

PRIMARY INS: ID # \_\_\_\_\_ GROUP # \_\_\_\_\_

NAME: \_\_\_\_\_ CARDHOLDER: \_\_\_\_\_ EFF DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CARDHOLDER DOB: \_\_\_\_\_ SEX: \_\_\_\_\_

PRIM INS TEL #: \_\_\_\_\_

SECONDARY INS: ID # \_\_\_\_\_ GROUP # \_\_\_\_\_

NAME: \_\_\_\_\_ CARDHOLDER: \_\_\_\_\_ EFF DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CARDHOLDER DOB: \_\_\_\_\_ SEX: \_\_\_\_\_

**RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS**

I hereby authorize CWPW to release information concerning treatment or services rendered to Medicare/other insurance carriers responsible for my or my dependent's care. I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to CWPW for any services rendered. I have been advised that if my insurance requires a co-pay it is due at the time of the visit. Otherwise, a \$25 surcharge will be added to my bill.

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_