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 form to 617-730-0178 or e-mail completed Affiliate form to:
Joe Founds: joseph.founds@childrens.harvard.edu: Office: 857-218-4007 Pager: #1400 or
Dance Affiliates-Darnell Hardmon: darnell.hardmon@childrens.harvard.edu Office: 617-355-6884
Affiliate Group Urgent Contact Line: 857-218-5093
Katie Cogar: kathryn.cogar@childrens.harvard.edu Office: 857-218-5090