Hartford Area Pediatrics, P.C.
Thomas Binder, M.D. Meredith Barrows, M.D.
Colleen Gerrity, M.D. Matthew Serna, M.D.
21B Arts Center Court Avon, CT 06001
Phone 860-678-9400 – Fax 860-678-9480

Date_____

Patient Name: _____ Last _____ Sex _____ DOB___ /___ /____

Street Address_____

City: _____ State: ____ Zip: _____

Primary # (Home/Cell) _____Secondary # (Home/Cell) _____

I give permission for Hartford Area Pediatrics to leave a message or appointment reminder for guardians of this child (children) at the following numbers: ☐ Home ☐ Cell ☐ Email

Preferred email: _____

Providing your email will give you access to our Patient Portal, Healow app, and receive communications from our office confirming appointments, statement information and office updates.

Parent /Guardian #1:

First Name:_____Last:_____

DOB___/___/_____ Address: Same as above ☐

Address:_____

City:_____State:_____Zip:_____

Home #_____Cell#_____

Is this person responsible for payment? ☐Yes ☐No

Does this person hold the insurance? ☐Yes ☐No

Insurance: _____

Employer:_____Work# _____

Parent/ Guardian #2:

First Name:_____Last:_____

DOB___/___/_____ Address: Same as above ☐

Address:_____

City:_____State:_____Zip:_____

Home #_____Cell#_____

Is this person responsible for payment? ☐Yes ☐No

Does this person hold the insurance? ☐Yes ☐No

Insurance: _____

Employer:_____Work# _____

Emergency Contact: (if other than Guardian)

Name: _____

Address: _____

City: _____State: ____ Zip: _____

Phone: _____Relation_____

Patient Information:

Primary Language: ☐ English ☐ Spanish ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Decline to specify ☐ Non-Hispanic or Latino

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Black or African American ☐ White ☐ Other ☐ Decline to specify

Sibling Information

First Name: _____ Last _____ Sex _____ DOB ___/___/____

First Name: _____ Last _____ Sex _____ DOB ___/___/____

First Name: _____ Last _____ Sex _____ DOB ___/___/____