

The Human Relations Service

REGISTRATION FORM

**GUARANTOR:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_  
(Responsible for Payment)

**CONTRACT, if applicable (Circle):**

Dover Schools	Babson College	Chapel Hill/Chauncy Hall School
Meadowbrook School	Dover-Sherborn Schools	Town of Lincoln
Wayland Schools	Needham Schools	Sherborn Schools
	Wellesley College	Town of Wellesley

**PATIENT:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_  
Street Town State/Zip

**TELEPHONES:** Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**FAMILY NAME ( if different):** \_\_\_\_\_

**ADDRESS (if different):** \_\_\_\_\_  
Street Town State/Zip

FAMILY MEMBERS

Name	Date of Birth	Relationship to Patient	Sex
			M F
			M F
			M F
			M F
			M F

**DOES THE FAMILY HAVE HEALTH INSURANCE?** YES { } NO { } MEDICAID { } (See below)

**COMPANY:** \_\_\_\_\_ **TELEPHONE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_  
Street Town State/Zip

**SUBSCRIBER (if not guarantor):** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_  
Street Town State/Zip

**TELEPHONE:** \_\_\_\_\_ **POLICY NUMBER(S):** \_\_\_\_\_

**IMPORTANT: SIGNATURE REQUIRED ON OTHER SIDE.**

I have read the accompanying Financial Information Brochure. I give HRS permission to verify the above information with my insurance carrier. I understand that although my insurance may cover all or part of the charges, I am responsible for any/all unpaid balances not covered for any reason, including cancellations with less than 24 hours notice. I accept full responsibility for prompt payment for services rendered to my family and me. I have also read the accompanying Client Rights, Privacy and Confidentiality Brochure.

\_\_\_\_\_  
**Signed (Guarantor)**

\_\_\_\_\_  
**Date**

**FOR MEDICAID RECIPIENTS (Complete for each family member covered):**

Name	Date of Birth	Relationship to Patient	Sex
			M F
			M F
			M F
			M F
			M F

**You must present your card each time at each visit so that we can verify your eligibility/coverage.**