Pediatric Patient Registration Form

Section 1 - ***If you have more than one child and their registration information is the same, please skip to Section 2. Our staff will copy and return the form to you to complete Section 1 - (one form for each child).***

Patient (Legal) Last Name	First Name (Legal)	Preferred Name	Full Middle Name

Date of Birth	Gender	Social Security Number	Primary Care Physician	Religious Affiliation
/ /	Female __ Male __	- -		

Preferred Spoken Language	Preferred Written Language	Need an Interpreter?
		Yes or No

Ethnicity **(circle one)**	Race **(circle one)**
Hispanic or Latino / Non Hispanic or Latino or Unknown	Asian / Black African-American / Caucasian / Hispanic Non Caucasian Native American-Eskimo / Multi-Racial-Other / Decline to State - Unknown

Section 2 - ***Please complete this section and the back page.***

Patient Address (Number, Street, Apt #)	City	State	Zip Code
Bill To Address (if same as above, leave blank)			
Mailing Address (Number, Street, Apt #)	City	State	Zip Code

Parent or Legal Guardian Information

Parent/Legal Guardian of Minor	Date Of Birth	Relationship to Minor
	/ /	

Phone 1 **(Home, Cell, Work/Other)**	( ) -	Would you like an appointment reminder call? **Yes or No**	
Phone 2 **(Home, Cell, Work/Other)**	( ) -	Phone 3 **(Home, Cell, Work/Other)**	( ) -
Email Address	@	**.com** or **.net** or ._____ ***(circle one)***	

Parent/Legal Guardian of Minor	Date of Birth	Relationship to Minor
	/ /	

Phone 1 **(Home, Cell, Work/Other)**	( ) -	Phone 2 **(Home, Cell, Work/Other)**	( ) -

Emergency Contact

Emergency Contact's Name	Relationship to patient	Phone
		( ) -

Insurance Holder Information

Insurance Holder Name (Subscriber)	Date of Birth	Relationship to Patient	Phone Number
	/ /		( ) -
	/ /		( ) -

Insurance Holder Employer Information

Employer Name & Address (Number, Street, Apt #, City, State, Zip Code)	Employer Phone Number
	( ) -
	( ) -

Do you have a copy of your insurance card with you today? Yes ___ No ___ ***(If no, please complete this section)***

Health Plan Information	Primary Health Plan	Secondary Health Plan
Health Plan Name		
Health Plan Address		
Phone Number	( ) -	( ) -
Subscriber Number		

Signature _____ **Relationship to Patient** _____ **Date** _____

Revised 10/1/17