PEDIATRIC PATIENT REGISTRATION FORM

Today's Date: ______________________ ***Clinic Name:*** ____________________________________

PATIENT INFORMATION: (Please use full legal name, no nicknames please)

Last Name: ______________________________ **First Name:** _____________________________ **Middle Name:** __________

Address: ____ **SS#** ____________________________

City: ____________________________________ **State:** _______________________ **Zip:** __________________

Home Phone #: (________) ___________________________ **Cell Phone: (________)** _____________________________

Date of Birth: ______________________ **Age:** _______________ **Sex: Female [ ]** **Male [ ]**

Emergency Contact Name: _______________________________________ **Emerg Phone #: (________)** __________-___________

PARENT INFORMATION: (List person or Insured name responsible for bill – use full legal name, no nicknames please)

****Person responsible for Bill:** ________**Mother** ________**Father** ________**Other** ______________________________

Other person who can give consent if parents cannot be reached (*MUST BE A RELATIVE*), please provide name and relationship:

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****Mom's First & Last Name:** ______________________________**DOB:** _______________ **SS#:**____________________

Mother's Maiden Name: ________________________________**Mother's Work Phone #**_____________________________

****Dad's First & Last Name:** ______________________________________**DOB:** _______________ **SS#:**______________

Married _______ **Divorced:** ___________ **Single:** _______ **Mom's Cell:** _____________________________________

Home Phone #: (______)________-_______________ **Dad's Cell:** __________________**Dad's Work Phone #**________________

Address (if different from above) ____

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Please provide name of patients siblings: ____

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INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

PRIMARY INSURANCE:

****Policy Holder's name :** ____________________________ **Insurance Name:** ____________________________

****Policy Holder's Social Security #:** ______________________ ****Policy Holder's DOB:** ________________________

****Policy / ID #:** ____________________________ **Group #:** ____________________ **Eff Date:** _______________

Insurance Claims Address & Phone: ____

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SECONDARY INSURANCE:

****Policy Holder's name :** ____________________________ **Insurance Name:** ____________________________

****Policy Holder's Social Security #:** ______________________ ****Policy Holder's DOB:** ________________________

****Policy / ID #:** ____________________________ **Group #:** ____________________ **Eff Date:** _______________

Insurance Claims Address & Phone: ____

**** Required Fields** **Please attach a copy of patient's insurance card in addition to completing all information on this form.**

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Please read and sign back of form.