

PATIENT REGISTRATION



DATE: _____

PARENT/GUARDIAN # 1 _____ DOB _____

Address: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Email: _____ Employer: _____

OK to leave messages? Home Cell Work **RELATIONSHIP TO CHILD:** _____

PARENT/GUARDIAN # 2 _____ DOB _____

Address: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Email: _____ Employer: _____

OK to leave messages? Home Cell Work **RELATIONSHIP TO CHILD:** _____

Child: _____ DOB _____ Nickname: _____ Male Female

Race: White Black Asian Pacific Islander American Indian **Ethnicity:** Hispanic Non-Hispanic Decline to answer

Child resides with: Both Parent 1 Parent 2 **Check only if one parent has sole legal custody:** Parent 1 Parent 2

Child: _____ DOB _____ Nickname: _____ Male Female

Race: White Black Asian Pacific Islander American Indian **Ethnicity:** Hispanic Non-Hispanic Decline to answer

Child resides with: Both Parent 1 Parent 2 **Check only if one parent has sole legal custody:** Parent 1 Parent 2

Child: _____ DOB _____ Nickname: _____ Male Female

Race: White Black Asian Pacific Islander American Indian **Ethnicity:** Hispanic Non-Hispanic Decline to answer

Child resides with: Both Parent 1 Parent 2 **Check only if one parent has sole legal custody:** Parent 1 Parent 2

Child: _____ DOB _____ Nickname: _____ Male Female

Race: White Black Asian Pacific Islander American Indian **Ethnicity:** Hispanic Non-Hispanic Decline to answer

Child resides with: Both Parent 1 Parent 2 **Check only if one parent has sole legal custody:** Parent 1 Parent 2

Child: _____ DOB _____ Nickname: _____ Male Female

Race: White Black Asian Pacific Islander American Indian **Ethnicity:** Hispanic Non-Hispanic Decline to answer

Child resides with: Both Parent 1 Parent 2 **Check only if one parent has sole legal custody:** Parent 1 Parent 2

EMERGENCY CONTACT: _____ Phone: _____ Relationship to child: _____

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INSURANCE: _____ POLICY # _____ GROUP # _____

Subscriber's name: _____ DOB: _____ Relationship to child: _____

INSURANCE: _____ POLICY # _____ GROUP # _____

Subscriber's name: _____ DOB: _____ Relationship to child: _____

PREFERRED PHARMACY: _____ TOWN: _____ PHONE: _____

Whom may we thank for referring you to us? _____

The above information is true to the best of my knowledge. I authorize my benefits to be paid directly to Pediatric Partners, LLC. I understand that I am financially responsible for any balance unpaid. I also authorize Pediatric Partners, LLC to release any information required to process my claim, including the release of my child/dependent's medical information by or between any of my treating physicians and my insurer, HMO, health benefits payer, or any other entity (including but not limited to third party administrators, management companies and provider networks) included in the administration of my child/dependent's health benefits.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

PRINTED NAME: _____ RELATIONSHIP TO CHILD: _____