PATIENT REGISTRATION

PEDIATRIC PARTNERS LLC
partnering with families

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:** ________________

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Subscriber's name: __________________________ **DOB:** _________________ **Relationship to child:** ________________

PREFFERED 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:** __________________