

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:

**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) _____

Please provide name of patients siblings: _____

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: _____

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.

Please read and sign back of form.

