PEDIATRIC PATIENT REGISTRATION FORM

*Today's Date:*_____ *Clinic Name:* ABC PEDIATRICS

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 #: (_____) _____

**Person responsible for Bill: _____Mother _____Father _____Other _____

Other person who can give consent if parents cannot be reached (*MUST BE A RELATIVE*)

Name: _____ 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 _____ Dad's Work Phone #: (____) _____

Home Phone #: (____) _____ Mom's Cell: (____) _____ Dad's Cell: (____) _____

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 SS#: _____ **Policy Holder's DOB: _____

**Policy / ID #: _____ Group #: _____ Eff Date: _____

Insurance Claims Address & Phone: _____

_____

SECONDARY INSURANCE:

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

**Policy Holder's SS#: _____ **Policy Holder's DOB: _____

**Policy / ID #: _____ Group #: _____ Eff Date: _____

Insurance Claims Address & Phone: _____

_____

**Required Fields *Please read and sign back of form.*