PEDIATRIC REGISTRATION FORM

Patient Information (Children under age 18)

Last Name________ First Name________ Middle Initial________

Street Address________ Nickname________

City________ State________ ZIP________ Home Phone________

Date of Birth________ Sex ☐ M ☐ F Student? ☐ Yes ☐ No

Names of siblings or other family members coming to this practice________

Responsible Party Information (Person who accompanies child to visit)

Last Name________ First Name________ Middle Initial________

Street Address________ ☐ Same as Patient

City________ State________ ZIP________

Home Phone________ Work Phone________ Cell Phone________

Email Address________

Other Parent Last Name________ First Name________ Middle Initial________

Street Address________ ☐ Same as Patient

City________ State________ ZIP________

Home Phone________ Work Phone________ Cell Phone________

Email Address________

Primary Insurance Information

Insurance Carrier Name________ Copay________ Effective Date________

Subscriber's Name________ Subscriber's Date of Birth________

Name of Employer Providing Insurance________

Patient Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other Subscriber's Sex ☐ M ☐ F

Secondary Insurance Information

Insurance Carrier Name________ Copay________ Effective Date________

Subscriber's Name________ Subscriber's Date of Birth________

Name of Employer Providing Insurance________

Patient Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other Subscriber's Sex ☐ M ☐ F

How did you hear about our practice?

☐ Family ☐ Friend ☐ Newspaper ☐ Radio ☐ TV ☐ Phone book ☐ PriMed Website ☐ Internet
☐ Signage ☐ Insurance company directory ☐ Other physician ☐ Hospital

The undersigned patient or individual acting on behalf of the patient agrees that the above facts are correct.

Signature________ Date________