



Treating You Well.

Pediatric Registration Form

Patient Information (Children under age 18)				Account Number (office use only)	
Last Name		First Name	MI	DOB	Social Security #
Street Address			City	State	ZIP Code
Maiden name of patient's mother					
Names of siblings or other family members who come to this practice:					
Responsible Party (Person who accompanies child to visit)					
Last Name			First Name		MI
Street Address			City	State	ZIP Code
Home Phone		Work Phone		Cell Phone	
Email Address					
Other Responsible Party					
Last Name			First Name		MI
Street Address			City	State	ZIP Code
Home Phone		Work Phone		Cell Phone	
PRIMARY Insurance Name		Copay	SECONDARY Insurance Name		Copay
Subscriber Name		Subscriber DOB	Subscriber Name		Subscriber DOB
Subscriber ID No.		Group No.	Subscriber ID No.		Group No.
Patient's Relation to Subscriber			Patient's Relation to Subscriber		
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
Please provide the following information so we may improve patient communication and care.					
Primary Language (select one)					
<input type="checkbox"/> English		<input type="checkbox"/> Arabic	<input type="checkbox"/> Bengali	<input type="checkbox"/> Chinese	<input type="checkbox"/> German
<input type="checkbox"/> Japanese		<input type="checkbox"/> Mandarin	<input type="checkbox"/> Portuguese	<input type="checkbox"/> Russian	<input type="checkbox"/> Spanish
Ethnicity			Race		
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> NOT Hispanic or Latino			<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Asian		
The undersigned individual agrees that the above facts are correct.					

Signature _____ **Date** _____