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 ☐ Self ☐ Spouse ☐ Child ☐ Other		**Patient's Relation to Subscriber** ☐ Self ☐ Spouse ☐ Child ☐ Other	

Please provide the following information so we may improve patient communication and care.

Primary Language *(select one)*

☐ English ☐ Arabic ☐ Bengali ☐ Chinese ☐ German ☐Hindi (Urdu)
☐ Japanese ☐ Mandarin ☐ Portuguese ☐ Russian ☐ Spanish

Ethnicity
☐ Hispanic or Latino
☐ NOT Hispanic or Latino

Race
☐ American Indian or Alaska Native ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Asian

The undersigned individual agrees that the above facts are correct.

Signature____ **Date**________________