Patient Registration Form

(Please print and complete all sections)

Patient's Information	*Patient's Information*
Child #1: DOB: M/F	**Child #2:** DOB: M/F
Child's Race (circle one): White, Black, Hispanic, Other _____	Child's Race (circle one): White, Black, Hispanic, Other _____
Child's Primary Language (circle one): English, Spanish, Other _____	Child's Primary Language (circle one): English, Spanish, Other _____
Child's Ethnicity (circle one): Non-Hispanic, Hispanic	Child's Ethnicity (circle one): Non-Hispanic, Hispanic
Child #3: DOB: M/F	**Child #4:** DOB: M/F
Child's Race (circle one): White, Black, Hispanic, Other _____	Child's Race (circle one): White, Black, Hispanic, Other _____
Child's Primary Language (circle one): English, Spanish, Other _____	Child's Primary Language (circle one): English, Spanish, Other _____
Child's Ethnicity (circle one): Non-Hispanic, Hispanic	Child's Ethnicity (circle one): Non-Hispanic, Hispanic
Mother's Information	*Father's Information*
Name: DOB:	Name: DOB:
Primary/Day Phone#: WK/HM/CELL	Primary/Day Phone#: WK/HM/CELL
Secondary Phone#: WK/HM/CELL	Secondary Phone#: WK/HM/CELL
Address Apt#	Address Apt#
City State Zip	City State Zip

Preferred Daytime Phone Number: _____ Preferred Email Address: _____

Would You Like Access to Patient Portal For Appointment Reminders, Lab Results, Referral Requests, Etc? Yes No

Authorize Text Notifications: Yes No Authorize Email Notifications: Yes No

Primary Insurance Information

Policy Holder's Name: _____

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

Primary Insurance Company: _____ Customer Serv Phone#:_____

Insurance Address: _____

Policy Number: _____ Group Number: _____

Employer's Name: _____ Employer's Phone#:_____

Secondary Insurance Information

Policy Holder's Name: _____

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

Primary Insurance Company: _____ Customer Serv Phone#:_____

Insurance Address: _____

Policy Number: _____ Group Number: _____

Employer's Name: _____ Employer's Phone#:_____

I acknowledge the above information provided is correct. I authorize treatment and payment for all medical services rendered by the medical providers and staff of ABC Pediatrics, PC.

Please sign and date: Guarantor/Responsible Guardian _____

Relationship to Patient _____ Date_____