Kids'Corner PEDIATRICS

1114 Bell Shoals Rd
Brandon, FL. 33511
Phone (813) 940-8140
Fax (813) 940-8148

PATIENT REGISTRATION FORM

PERSONAL DATA **DATE** ____/____/____

CHILD'S NAME_____ DOB_____/_____/_____

SEX_____(F) _____(M) SS#_____-_____-_____ BEST DAYTIME PHONE_____-_____-_____

PARENT #1_____ DOB_____/_____/_____ SS#_____-_____-_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

CELL PHONE_____-_____-_____ WORK PHONE_____-_____-_____ HOME PHONE_____-_____-____

EMAIL_____ OCCUPATION_____

PARENT #2_____ DOB_____/_____/_____ SS#_____-_____-_____

ADDRESS **(if different from above)** _____

CITY_____ STATE_____ ZIP CODE_____

CELL PHONE_____-_____-_____ WORK PHONE_____-_____-_____ HOME PHONE_____-_____-____

EMAIL_____ OCCUPATION_____

EMERGENCY CONTACT **OTHER THAN PARENT**_____

RELATIONSHIP_____ PHONE_____-_____-_____ ALTERNATE PHONE_____-_____-____

PREFERRED COMMUNICATION

__ TEXT FOR APPOINTMENT REMINDERS/MESSAGES

__ EMAIL FOR APPOINTMENT REMINDERS/MESSAGES

PREFERRED PHARMACY_____

PHARMACY ADDRESS AND PHONE_____

ALLERGIES_____

PREVIOUS DOCTOR/ADDRESS_____

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PATIENT REGISTRATION FORM CONTINUED

CHILD'S NAME_____ DOB_____/_____/_____

INSURANCE INFORMATION

MEDICAID ___ YES ___ NO

PRIMARY INSURANCE COMPANY_____

SUBSCRIBER #_____ GROUP #_____

POLICY HOLDER_____ DOB_____/_____/_____

EMPLOYER_____

SECONDARY INSURANCE COMPANY_____

SUBSCRIBER #_____ GROUP #_____

POLICY HOLDER_____ DOB_____/_____/_____

EMPLOYER_____

ACKNOWLEDGEMENT AND SIGNATURE

I confirm that the information on this form is current and accurate information. I understand that I am financially responsible for all charges whether or not paid by the insurance.

Signature_____ Date_____/_____/_____

Name (Print)_____ Relationship to Patient_____