Partners in Pediatrics Registration*required fields

***PatientName**_____Sex_____DOB_____

Who is the primary contact_____

***Mother/Responsible Party Information**: Relationship _____

Name_____SS#_____DOB_____

Mailing_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____

Employer_____ Employers Phone _____

Email address_____Would you like a Portal Account? ❑Yes (*please notify staff)* ❑ No

Preferred Method of contact (circle one) ***bold/italic*** *suggested*:

For Medical issues: ***Cell*** Work Home

For Appointment Reminders: ***Text*** Cell Work Home Email

***Father/Responsible Party Information:** Relationship _____

Name_____SS#_____DOB_____

Mailing_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____

Employer_____EmployersPhone_____

Email address_____Would you like a Portal Account? ❑Yes (*please notify staff)* ❑ No

Preferred Method of contact (circle one) ***bold/italic*** *suggested*:

For Medical issues: ***Cell*** Work Home

For Appointment Reminders: ***Text*** Cell Work Home Email

Siblings

Name _____ DOB _____ Name _____DOB_____

Name _____ DOB _____ Name _____DOB_____

Insurance **(If the subscriber to the insurance is not listed as a 'responsible party' above please provide their name, address, date of birth, and Social Security number.)***

*****Primary Company Name_____ Subscriber Name_____

Group Number_____ Policy Number_____

*****Secondary Company Name_____ Subscriber Name_____

Group Number_____PolicyNumber_____

Emergency Contact (other than parents)

*****Name_____ Phone_____

Language_____

Ethnicity: ❑ American Indian or Alaskan Native ❑ Asian ❑ Black ❑ Hawaiian Native or Pacific Islander ❑ White ❑ Hispanic

Today's Date_____