Patient Registration Form

Patient Name:_____ **DOB:**_____ **Sex:**_____ **SSN/ID:**_____

Address (Street/City/Sate/Zip):_____

Home Phone:_____ **Mobile Phone:**_____

Ethnicity: Hispanic/Non-Hispanic/Unknown **Race:** Asian/American Indian/African American/Native Hawaiian or Pacific Islander/White

Parent /Guardian Name:_____ **Relationship to Patient:**_____ **Primary Responsible:** Y/N

DOB:_____ **SSN:**_____ **Lives w/Patient:** Y/N **Financial Responsibility:** Y/N

Address (Street/City/Sate/Zip):_____

Home Phone:_____ **Mobile Phone:**_____ **Email:**_____

Occupation:_____ **Employer:**_____ **Work Phone:**_____

Parent /Guardian Name:_____ **Relationship to Patient:**_____ **Primary Responsible:** Y/N

DOB:_____ **SSN:**_____ **Lives w/Patient:** Y/N **Financial Responsibility:** Y/N

Address (Street/City/Sate/Zip):_____

Home Phone:_____ **Mobile Phone:**_____ **Email:**_____

Occupation:_____ **Employer:**_____ **Work Phone:**_____

Note: *please note only primary responsible selected above will be provided with patient medical information.*

Medical Insurance Policy/ Holder Information:

Primary Insurance:_____ **Policy#:**_____ **Group#:**_____

Subscriber Name:_____ **Subscriber DOB:**_____ **Subscriber SSN:**_____

Secondary Insurance:_____ **Policy#**_____ Group#_____

Subscriber Name:_____ **Subscriber DOB:**_____ **Subscriber SSN:**_____
(If different than Primary Subscriber)

Siblings Information (SSN is need if registering siblings as well)**:**

Name:_____ **DOB:**_____ **Relationship:** Brother/Sister **Register:** Y/N **SSN:**_____

Name:_____ **DOB:**_____ **Relationship:** Brother/Sister **Register:** Y/N **SSN:**_____

Name:_____ **DOB:**_____ **Relationship:** Brother/Sister **Register:** Y/N **SSN:**_____

Name:_____ **DOB:**_____ **Relationship:** Brother/Sister **Register:** Y/N **SSN:**_____

Name:_____ **DOB:**_____ **Relationship:** Brother/Sister **Register:** Y/N **SSN:**_____

Triangle Kids CARE PEDIATRICS

If Parents are Divorced or Separated:

Who has Custody:_____; Any legal restrictions for non-custodial parent seeking or consenting to medical treatment of the child Y/N, if Yes, please explain_____

_____ _____
Signatures Date

_____ _____
Relationship to Patient Witness Signatures

Emergency Contact (Other than Parents):

Name:_____ **Relationship:**_____ **Phone:**_____

Name:_____ **Relationship:**_____ **Phone:**_____

Other than Parent(s)/Guardian listed Above, who is authorized to bring child for treatment/appointments; please provide information below and sign:

Name:_____ **Name:**_____

Relationship:_____ **Relationship:**_____

Address: _____ **Address:**_____

Phone:_____ **Phone:**_____

_____ _____
(Print Name) (Sign)

Note: By signing this you understand that your child's health information will/can be shared with individuals listed above for the purposes of diagnosis.

Preferred Pharmacy: _____