



REGISTRATION FORM

(Please Print Legibly and Complete Entire Form in Black Ink Only)

PEDIATRICS

Primary Physician: _____

Account#: _____

PATIENT INFORMATION

Patient's Full Name: _____		DOB: _____	Sex: _____
Patient's Street Address: _____		City: _____	State: _____ Zip: _____
Race: (check one) <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Declined			Preferred Language: _____
Ethnicity: (check one) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined			
Preferred Pharmacy Name: _____		Location: _____	Phone#: _____

PARENTAL/GUARDIAN INFORMATION

Parent or Legal Guardian	Parent or Legal Guardian
Name: _____	Name: _____
DOB: _____ SS#: _____	DOB: _____ SS#: _____
Relationship to Patient: _____	Relationship to Patient: _____
<input type="checkbox"/> Address same as pt.	<input type="checkbox"/> Address same as pt.
Mailing Address: _____ Street Address	Mailing Address: _____ Street Address
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Primary Phone #: (_____) _____ - _____ H W C	Primary Phone #: (_____) _____ - _____ H W C
Secondary Phone#: (_____) _____ - _____ H W C	Secondary Phone#: (_____) _____ - _____ H W C
Employer: _____	Employer: _____

MEMBERS LIVING IN HOUSEHOLD OTHER THAN GUARDIANS

NAME	DOB	RELATIONSHIP TO PT	NAME	DOB	RELATIONSHIP TO PT
1.			4.		
2.			5.		
3.			6.		

IN CASE OF EMERGENCY

Name of Emergency Contact(not living at same address & other than guardian) : _____

Relationship to Patient: _____ Contact #: _____

APPOINTMENT CONFIRMATION

I prefer to be sent a text at: _____ I prefer to be called at: _____

I can be emailed at: _____

Note: By providing my email address, I authorize email contact by Island Coast Pediatrics

I WAS REFERRED TO ISLAND COAST PEDIATRICS BY:

- SWFL Premier OB Lee Health OB Other OB Community Event Insurance List SW FL Parent and Child
 ICP Website ICP Facebook Page Web Search Chamber of Commerce Family and Friends

Guarantor Signature _____ Relationship to Patient: _____

Date: _____ Reviewed by: _____ Entered by: _____
(Office Use Only) (Office Use Only)