



Pediatric Family Registration Form

New Patient Edit Information

This form can be used for all children UNDER the AGE of 18

Please complete this form to ensure proper billing of your services. **Please Print.**

Today's Date: _____

Patient Information

Child #1 Last Name _____ First _____ MI _____
Preferred Name: _____ Date of Birth _____
Gender: M F Transgender Neither exclusively M or F Decline to specify
Minor's Cell Phone _____

Child #2 Last Name _____ First _____ MI _____
Preferred Name: _____ Date of Birth _____
Gender: M F Transgender Neither exclusively M or F Decline to specify
Minor's Cell Phone _____

Child #3 Last Name _____ First _____ MI _____
Preferred Name: _____ Date of Birth _____
Gender: M F Transgender Neither exclusively M or F Decline to specify
Minor's Cell Phone _____

Child #4 Last Name _____ First _____ MI _____
Preferred Name: _____ Date of Birth _____
Gender: M F Transgender Neither exclusively M or F Decline to specify
Minor's Cell Phone _____

Ethnicity:
 Hispanic or Latino Not Hispanic or Latino
 Declined to specify

Preferred Language:
 English Spanish
 Other _____

Race:
 American Indian/Alaska Native Asian
 African American Native Hawaiian/Pacific Islander
 White Declined to specify

Translator?
 YES NO
Comments: _____

Primary Care Provider:
Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____

Referring Provider:
Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____

Patient's Primary Address

Address: _____
City, State, Zip: _____
Home Phone: (_____) _____

Patient's Reminders/Communication

This section is related to communication and Patient Portal access (See 'Patient Portal FAQs')

Please provide the contact information for the person who is to receive the reminders/communication for the patient(s).
Home Phone: (_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____

Web Enabled Patient E-Mail: _____
(must be patient's email if over age 12)

No Email Patient Refused Parent/Proxy E-Mail: _____

Voice Enabled Messaging English Spanish **Preferred method:** Home Cell Work
 Text Enabled Messaging English Spanish **Preferred method:** Home Cell Work

Types of reminders you wish to receive:
 Appointments Lab results Health Maintenance RX Confirmation General ALL NONE

Preferred Pharmacy Information

Primary Pharmacy Name, Address & Phone #: _____

Patient's Parental Information

Patient lives with Both Parents Parent A Parent B Guardian*
Custody Agreement YES NO N/A (If YES, please provide copy)

Parent/Guardian (A) Name: _____

Cell Phone: _____

Parent (A) Address same as patient YES NO

If NO- please complete

Addr: _____

City, State, Zip: _____

Parent (A) Date of Birth: _____

Home phone: _____

Email Address: _____

Employment Status:

Employed FT Employed PT Not Employed

Self Active Military Retired Reserved - Nat'l assignmt

Employer: _____

Other please explain: _____

*If YES to Guardian, please provide court documents

Parent/Guardian (B) Name: _____

Cell Phone: _____

Parent (B) Address same as patient YES NO

If NO- please complete

Addr: _____

City, State, Zip: _____

Parent (B) Date of Birth: _____

Home phone: _____

Email Address: _____

Employment Status:

Employed FT Employed PT Not Employed

Self Active Military Retired Reserved - Nat'l assignmt

Employer: _____

Emergency Contact Information

(please provide contact other than parents)

Last Name, First Name: _____ Relationship to Patient: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Insurance Information

Please provide a copy of ALL Insurance cards

Please let us know if this is a Worker's Comp Issue MVA Legal Case School Insurance

Self-Pay (no insurance) Patient insured under: Mother's Insurance Father's Insurance Other

Medicaid - ID Number: _____

PRIMARY INSURANCE NAME:

Benefit Plan Name _____

Member ID: _____ Group#: _____ Effective Date: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Gender: M F Transgender Neither exclusively M or F Decline to specify

PCP listed on card: _____

SECONDARY INSURANCE NAME:

Benefit Plan Name _____

Member ID: _____ Group#: _____ Effective Date: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Gender: M F Transgender Neither exclusively M or F Decline to specify

PCP listed on card: _____

Guarantor Information

Guarantor must initial to acknowledge that you are aware that you will receive the bill and be financially responsible for this patient. Guarantor Initial: _____

Relationship: Father Mother Other (specify): _____

Last Name: _____ First Name: _____

Date of Birth: _____ Gender: M F Transgender Neither exclusively M or F Decline to specify

Address: _____

City, State, Zip: _____

Home phone: _____ Cell Phone: _____ Email: _____

Guarantor's Employer: _____

Work phone: _____

Address: _____

City, State, Zip: _____