

Pediatric Patient Registration and Demographic Form

Please complete all sections of this registration form for the patient's medical record.

1. Patient Information

| | | | |
|-----------------------------|----------------------|--------------------------------------|----------------------|
| Patient Last Name: | <input type="text"/> | Patient First Name: | <input type="text"/> |
| Middle Name: | <input type="text"/> | Preferred Name/Nickname: | <input type="text"/> |
| Date of Birth (MM/DD/YYYY): | <input type="text"/> | Gender (Identity/Assigned at Birth): | <input type="text"/> |
| Home Address: | <input type="text"/> | | |
| City: | <input type="text"/> | State & Zip Code: | <input type="text"/> |
| School or Daycare Name: | <input type="text"/> | Current Grade Level: | <input type="text"/> |

2. Parent / Legal Guardian Information

Primary Contact Guardian

| | | | |
|--------------------------|----------------------|-----------------------------|----------------------|
| Last Name: | <input type="text"/> | First Name: | <input type="text"/> |
| Relationship to Patient: | <input type="text"/> | Date of Birth (MM/DD/YYYY): | <input type="text"/> |
| Primary Phone: | <input type="text"/> | Alternate Phone: | <input type="text"/> |
| Email Address: | <input type="text"/> | | |

Secondary Contact Guardian

| | | | |
|--------------------------|----------------------|-----------------------------|----------------------|
| Last Name: | <input type="text"/> | First Name: | <input type="text"/> |
| Relationship to Patient: | <input type="text"/> | Date of Birth (MM/DD/YYYY): | <input type="text"/> |
| Primary Phone: | <input type="text"/> | Alternate Phone: | <input type="text"/> |

3. Insurance Information

| | | | |
|------------------------------|----------------------|-------------------------------------|----------------------|
| Insurance Company Name: | <input type="text"/> | Subscriber Full Name: | <input type="text"/> |
| Subscriber DOB (MM/DD/YYYY): | <input type="text"/> | Subscriber Relationship to Patient: | <input type="text"/> |
| Policy ID / Member ID: | <input type="text"/> | Group Number: | <input type="text"/> |

4. Emergency Contact (Other than Parents/Guardians)

| | | | |
|----------------|----------------------|--------------------------|----------------------|
| Full Name: | <input type="text"/> | Relationship to Patient: | <input type="text"/> |
| Primary Phone: | <input type="text"/> | Alternate Phone: | <input type="text"/> |

5. Primary Care Pediatrician Referral

| | | | |
|------------------------------|----------------------|-----------------------|----------------------|
| Referring Pediatrician Name: | <input type="text"/> | Clinic/Practice Name: | <input type="text"/> |
| Clinic Phone Number: | <input type="text"/> | Clinic Fax Number: | <input type="text"/> |

6. Consent and Signature (Office Print Use Only)

Parent/Guardian Signature: Date (MM/DD/YYYY):