Patient Registration

kids first pediatrics

Patient's Legal Name: ______________________________
Last First Middle

Mailing Address: ______________________________
Street or P.O. Box Apt #

____
City State Zip

Date of Birth: ____________ **SS #:** ____________ **Sex:** ☐ M ☐ F

Cell Phone: (____) ____________ **Home Phone:** (____) ____________

Email: ______________________________

Child's Race: ☐ American Indian or Alaska Native ☐ Asian ☐ African American ☐ White ☐ Unknown ☐ Patient Declined ☐ Other: ____________

Child's Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient Declined ☐ Unknown

Adopted/Custody: ☐ Yes ☐ No (If yes, please provide legal documentation for patient's chart)

Preferred Provider: ____________ **Preferred Language:** ____________

PARENT/GUARDIAN INFORMATION

Parent/Legal Guardian: ______________________________

Date of Birth: ____________ SS # : ____________

Address (if different): ______________________________

____

Home Phone: (____) ____________ Cell: : (____) ____________

Parent/Legal Guardian: ______________________________

Date of Birth: ____________ SS # : ____________

Address (if different): ______________________________

____

Home Phone: (____) ____________ Cell: : (____) ____________

Siblings & DOBs: ______________________________

PRIMARY INSURANCE INFORMATION

Plan Name: ____________ Policy ID #: ____________ Group #: ____________

Policy Holder: ____________ DOB: ____________ SS #: ____________

Patient's Relationship to Policy Holder: ____________ Copay: ☐ Y ☐ N (If yes) Amount: ____________

SECONDARY INSURANCE INFORMATION

Plan Name: ____________ Policy ID #: ____________ Group #: ____________

Policy Holder: ____________ DOB: ____________ SS #: ____________

Patient's Relationship to Policy Holder: ____________ Copay: ☐ Y ☐ N (If yes) Amount: ____________

I agree that the above information is true and correct to the best of my knowledge. **If over the age of 14, the patient MUST sign this form.**

______________________________ ____________
Print Name (Patient or Guardian if under 14) Date

______________________________ ____________
Signature (Patient or Guardian if under 14) Relationship to Patient