PATIENT REGISTRATION FORM

Today's Date: *Choice Pediatrics*

Patient Information (Please use full legal name)

Last Name:_____ First Name:_____ Middle Name:_____

Preferred name/nickname:_____

Address:_____ SS#_____

City:_____ State:_____ Zip:_____

Home phone#:(_____)_____ Cell phone (_____)_____

Date of Birth:_____ Age:_____ Sex: [ ] Female [ ] Male

Emergency Contact Name_____ Emergency Phone # (_____)_____

PARENT INFORMATION: (List person or Insured name responsible for bill—use full legal name, please)

Relationship of Guarantor to Patient_____ Mother's maiden name_____

Mom's First and Last Name:_____ DOB:_____ SS#_____

Dad's First and Last Name:_____ DOB:_____SS#_____

Married [ ] Divorced [ ] Who has custody/legal guardianship?_____ Single [ ]

Home phone # (_____)_____ Mom's cell (_____)_____ Dad's cell(____)_____

Email address:_____ Best contact method [ ]Call (circle #) [ ]email [ ]text (circle #)

Address(if different from above)_____

Please provide names and ages of patient's siblings:_____

_____

INSURANCE INFORMATION: (Please allow us to photocopy your insurance ID cards)

PRIMARY INSURANCE:

Policy Holder's name:_____ Insurance Name:_____

Policy Holder's SS#_____ Policy Holder's DOB:_____

Policy/ID#:_____ Group#:_____ Eff. Date:_____

Insurance Claims Address & Phone:_____

SECONDARY INSURANCE:

Policy Holder's name:_____ Insurance Name:_____

Policy Holder's SS#_____ Policy Holder's DOB:_____

Policy/ID#_____ Group #:_____ Eff. Date:_____

Insurance Claims Address &Phone:_____

*Please tell us how you heard about us*_____