Pediatric Services, PA
Patient Registration

Child 1: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _____ *Primary Language:* _____

Ethnicity: Hispanic / Not Hispanic / Unknown *Race*: Am. Indian or Alaskan/Asian / Black / Hawaiian / White /Unknown
Circle one *Circle all that apply*

Country where patient was born: _____ Decline to Answer_____

Child 2: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _____ *Primary Language:* _____

Ethnicity: Hispanic / Not Hispanic / Unknown *Race*: Am. Indian or Alaskan/Asian / Black / Hawaiian / White /Unknown
Circle one *Circle all that apply*

Country where patient was born: _____ Decline to Answer_____

Child 3: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _____ *Primary Language:* _____

Ethnicity: Hispanic / Not Hispanic / Unknown *Race*: Am. Indian or Alaskan/Asian / Black / Hawaiian / White /Unknown
Circle one *Circle all that apply*

Country where patient was born: _____ Decline to Answer_____

Mailing Address:

_____
(Street or PO Box) *(City)* *(State & Zip)*

Home Phone: (_____) _____ - _____

Who lives at this household? _____
(Please note, this information is being requested to improve intake of your child's Social History.)

Emergency Contacts, <u>other than parents</u>: Name & Relationship

Name: _____ Relationship _____ *Phone*: _____

How would you ideally prefer to we contact you regarding (circle one):

Medical Issues: Home Phone / Work Phone / Cell Phone / Home Email

Appointment Reminders: Home Phone / Cell Phone / Home Email / Work Email

Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone / Home Email

Billing Statements: Home Address / Home Email / Work Email

General Practice Notices: Home Address / Home Phone / Cell Phone / Home Email

Patient Portal Notifications: Cell Phone / Home Email / Work Email

Contact 1 (Primary – will get all reminders):

Name: _____

Relation to Patient: _____ *Biological Relation to Patient:* _____

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____

Work Phone: (____) _____ - _____ *Cell Phone*: (____) _____ - _____

Home Email: ____ _____ *Work Email:* _____

Employer: _____ *Occupation:* _____

Contact 2:

Name: _____

Relation to Patient: _____ *Biological Relation to Patient:* _____

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____

Work Phone: (____) _____ - _____ *Cell Phone*: (____) _____ - _____

Home Email: _____ *Work Email:* _____

Employer: _____ *Occupation:* _____

Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records electronically? Yes / No / _____

Referred by:_____

Insurance:

Primary Policy: *Policy Holder's Name*: _____

Policy Holder's Birth Date: _____ *Policy Holder's Sex:* Male / Female

Insurance Carrier: _____ *ID#* _____

Secondary Policy: *Policy Holder's Name*: _____

Policy Holder's Birth Date: _____ *Policy Holder's SSN:* _____

Insurance Carrier: _____ *ID#* _____

If parents are divorced or separated please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, *please explain and provide a copy of any legal paperwork that supports this restriction.*

Do your children attend Daycare? Yes/No Nanny Full Time Part Time Location:_____

Smokers around child? Yes/No Father Mother Brother Sister Other:_____

Pets in home? Yes/No Dog(s) Cat(s) Fish Birds Gerbils Hamster Other:_____

Guns in home? Yes/No Guns are kept: Unloaded Locked Ammunition stored Separately