Pediatric Services, PA
Patient Registration

Information: *Last Name:* _____ *First Name:* _____ *MI:* _____

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

Ethnicity: Hispanic / Not Hispanic / Unknown
Circle one

Race: Am. Indian or Alaskan/Asian / Black / Hawaiian / White /Unknown
Circle all that apply

Country where patient was born: _____ Decline to Answer_____

Mailing Address:

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

Home Phone: (_____) _____ - _____

Email: _____

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

Emergency Contacts, other than parents: 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/Text to Phone

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

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*: _____*Date of birth*: _____

Policy Holder's SSN: _____ *Policy Holder's Sex:* Male / Female

Insurance Carrier: _____ *ID#* _____

Secondary Policy: *Policy Holder's Name*: _____*Date of birth*: _____

Policy Holder's SSN: _____ *Policy Holder's Sex:* Male / Female

Insurance Carrier: _____ *ID#* _____