

Pediatric Services, PA

Patient Registration

Date _____

Child 1: 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 _____

Child 2: 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 _____

Child 3: 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 Apartment #)

(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, other than parents: Name & Relationship

Name: _____ Relationship _____ Phone: _____

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

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

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

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

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

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: _____

ADDRESS IF DIFFERENT THAN CHILD: _____

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: _____

ADDRESS IF DIFFERENT THAN CHILD: _____

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# _____

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