Brownsboro Park Pediatrics

PATIENT REGISTRATION

Patient Name (First, MI, Last) ______________________________ Date of Birth__________

Preferred Name ______________________________ Gender ______Male ______Female

Address ____

City______________________________State________Zip ________________

Race ______________ Ethnicity: NON-HISPANIC HISPANIC DECLINE TO ANSWER (Circle One)

Primary Language Spoken In the Home____

Pharmacy ____________________ Pharmacy Address __________________________

How Did You Hear About Our Practice? ____

Emergency Contact (Outside of the Home) __________________Phone_______________

Other Children in the Home That Are Patients of This Practice_________________________

GUARANTOR/RESPONSIBLE PARTY INFORMATION

Name_________________________

Relationship to Child________________

DOB__________ SSN______-_____-______

Address (If different than patient)

____

____

Phone#__________ Cell __________Home

Name_________________________

Relationship to Child________________

DOB__________ SSN______-_____-______

Address (If different than patient)

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Phone# __________Cell __________Home

Is it ok to leave a message at the above numbers? ___Yes ___No

Email _________________________

Employer _______________________

Email _________________________

Employer _______________________

If Parents Are Divorced or Separated, Please Complete The Following Section.

Who Has Primary Custody? ______________________________ Please supply court documents.

Are there any legal restrictions that would keep the non-custodial parent from consenting to medical treatment or from obtaining information about the child's medical treatment? _____Yes _____No

If yes, please explain, and provide our office a copy of any legal documents that support the restrictions

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INSURANCE INFORMATION

Primary Insurance ____________________________ Employer ______________________________

Member/Subscriber ID# ______________________________ Group _________________________

Subscriber's Name __________________________________ DOB ___________________________

Subscriber's SSN __________________________________ Relationship to Patient _______________

Secondary Insurance ____________________________ Employer _____________________________

Member/Subscriber ID# ______________________________ Group _________________________

Subscriber's Name __________________________________ DOB ___________________________

Subscriber's SSN __________________________________ Relationship to Patient _______________

Signature_______________________________________ Today's Date_________________