Premier Pediatrics
Patient Registration

Mailing Address:

_____

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

Home Phone: (_____) _____ - _____ Pharmacy Phone: (_____) _____ - _____

Who lives at this household? _____

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

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

Ethnicity: Hispanic / Non-Hispanic / Unknown

Race: Asian / Black / Hawaiian / White

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

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

Ethnicity: Hispanic / Non-Hispanic / Unknown

Race: Asian / Black / Hawaiian / White

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

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

Ethnicity: Hispanic / Non-Hispanic / Unknown

Race: Asian / Black / Hawaiian / White

Insurance:

Primary Policy: Policy Holder's Name: _____

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

Insurance Carrier: _____

ID# _____ Group # _____

Secondary Policy: Policy Holder's Name: _____

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

Insurance Carrier: _____

ID# _____ Group # _____

Contact Questions:

Who should receive billing statements? _____

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

Emergency Contacts, other than parents: Name & Relationship

1: _____ Phone: (_____) _____ - _____

2: _____ Phone: (_____) _____ - _____

Main Contact: Name: _____ Relation to Patient: _____

Lives with patient? Yes / No Date of Birth: ___ / ___ / ___ Social Security #: ___ - __ - ____

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

Home Email: _____ Work Email: _____

Employer: _____ Occupation: _____

How would you ideally prefer to be contacted 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 #2: Name: _____ Relation to Patient: _____

Lives with patient? Yes / No Date of Birth: ___ / ___ / ___ Social Security #: ___ - __ - ____

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

Home Email: _____ Work Email: _____

Employer: _____ Occupation: _____

How would you ideally prefer to be contacted 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

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.

_____

_____