PATIENT REGISTRATION

PATIENT INFORMATION

Last Name, First Name Middle Initial			
Date of Birth		**Patient Gender (M / F)**	
Home Street Address:			
City, State Zip			

Race:

☐ White ☐ American Indian / Alaska Native ☐ Black/African American ☐ Asian

☐ Native Hawaiian ☐ Other Pacific Islander ☐ More than 1 Race ☐ Unreported / Refused to Report

Ethnicity:

☐ Hispanic / Latino ☐ Not Hispanic/Latino ☐ Unreported / Refused to Report

Preferred Language:

☐ English ☐ Spanish ☐ Portuguese ☐ American Sign Language

☐ Other _____

Home Phone:		**Work Phone:**		**Mobile Phone:**	

GUARANTOR INFORMATION

Last Name, First Name, Middle Initial					
Guarantor DOB		**Relation to Patient**			
Guar Home Phone:		**Guar Work Phone:**		**Guar Mobile Phone:**	

INSURANCE INFORMATION

Primary Insurance:			
Policy # / Suffix:		**Group #:**	
Primary Ins Subscriber:		**Subscriber DOB**	
Secondary Insurance:			
Policy # / Suffix:		**Group #:**	
2ndary Ins Subscriber:		**Subscriber DOB**	

PHARMACY INFORMATION

Primary Pharmacy:	
Pharmacy Address:	

I certify that the above information is accurate and will notify the office of any changes to my insurance. I authorize the payment of benefits for services rendered by the insurer to Bramblebush Pediatrics. I accept financial responsibility for all charges not covered or payable by my insurance. Payment for service is due at the time services are rendered. I am responsible for any co-pays or deductibles specified by the insurance company.

Responsible Party Signature **Date**