

NEW PATIENT REGISTRATION INFORMATION

Healthy Starts Pediatrics, PC

Please print, complete and return to our office

Parent(s) Name(s): _____ (mother) Date of Birth: _____
_____ (father) Date of Birth: _____

If you are not the parent of the child you are registering, please state your relationship to the child being registered:

(If not the parent, you will need to have paperwork proving legal guardianship)

Address: _____
Street City State Zip

Primary Phone #: _____

Is this a Home or Cell#? Home Cell
To whom does this # belong? _____

Alternate Phone number: _____

Is this a Home or Cell #? Home Cell
To whom does this # belong? _____

How many children will be enrolled in the practice? _____

Primary Health Insurance Company Name: _____

Primary Identification Number: _____ Group #: _____

Who holds the insurance (Mother / Father / Grandparent)? _____

What is this person's Date of Birth? _____

When was the insurance effective? _____

Name(s) of child(ren) covered by this plan: _____

Secondary Health Insurance Company Name: _____

Primary Identification Number: _____ Group #: _____

Who holds the insurance (Mother / Father / Grandparent)? _____

What is this person's Date of Birth? _____

When was the insurance effective? _____

Name(s) of child(ren) covered by this plan: _____

Are any of the children covered by a Medical Assistance or CHIP plan (not listed above) such as Aetna Better Health Kids, Geisinger, United Healthcare Community Plan for Kids, UPMC? Yes No

(Continued on back)

Please list children to be enrolled in the practice below:

- | | | | |
|-----------|--------|---------------|---------------|
| 1. | _____ | _____ | Male / Female |
| | (Name) | Date of Birth | |
| 2. | _____ | _____ | Male / Female |
| | (Name) | Date of Birth | |
| 3. | _____ | _____ | Male / Female |
| | (Name) | Date of Birth | |
| 4. | _____ | _____ | Male / Female |
| | (Name) | Date of Birth | |

Have you already requested records to be sent to our office? Yes No

Where will the records be coming from? _____
Office Name Phone Number

Do you give us permission to contact the office above if there are issues with receiving records? **Yes** **No**

Please complete, print and return to our office. This form can be hand-delivered or faxed to 717-909-3204.

OR you may mail this form to:

Healthy Starts Pediatrics, PC
845 Sir Thomas Court, Suite 7
Harrisburg, PA 17109

Once records are received and reviewed, a staff member will contact you to set up your first appointment. If we do not receive your records within 2 weeks after your request to set up an account, we will contact you.