Ashe Pediatrics
Patient Registration

Today's Date:_____

Name of child: Last_____ First_____ Middle _____
Date of Birth: _____ Male / Female Social Security # _____-_____-_____
Address (street, city, state, zip):_____
Mailing address (if different-PO Box):_____
Mailing address (city, state, zip):_____
Mother's Maiden name: _____ Child's school/Daycare:_____

Parent/guardian: Last_____ First_____ Middle _____
Date of Birth: _____ Male / Female Soc. Sec. # ____-__-____ D/L_____ State____
Address (street, city, state, zip):_____
Mailing address (if different-PO Box):_____
Mailing address (city, state, zip):_____
Home Phone: _____ Daytime #: _____ Cell #:_____ email:_____
Employer: _____ Relationship to child (circle): Parent / Guardian / Other_____

2nd Parent/guardian: Last_____ First_____ Middle _____
Date of Birth: _____ Male / Female Soc. Sec. # ____-__-____ D/L_____ State____
Address (street, city, state, zip):_____
Mailing address (if different-PO Box):_____
Mailing address (city, state, zip):_____
Home Phone: _____ Daytime #: _____ Cell #:_____ email:_____
Employer: _____ Relationship to child (circle): Parent / Guardian /Other_____

Child lives with: Mother / Father / Both Parents / Alternates / Other (specify) _____
Emergency Contact (name, relationship & phone):_____

Insurance Info: Medicaid / Health Choice / BCBS / United / Cigna / Aetna / Other (specify)_____
Insurance Address: _____
Insurance City, State, Zip: _____
Policy holder's name: _____ Policy holder DOB_____ SS#_____ Policy #_____ Group #_____

Other Children:
Full Name:_____ DOB_____ Health Concerns:_____
Full Name:_____ DOB_____ Health Concerns:_____
Full Name:_____ DOB_____ Health Concerns:_____
Full Name:_____ DOB_____ Health Concerns:_____

Please circle (regarding your child):

1. **Preferred Language** (for info & handouts)
English/Spanish/Hmong/Other_____

2. **Ethnicity:** Hispanic / Not Hispanic

3. **Race:** American Indian / Alaska Native / Asian / African American / Native Hawaiian / Other Pacific Islander / White

Note: Info collected is used only for reports and is not associated with individual patient names.

Does Child Have Drug Allergies: yes / no

If yes, list _____ Reaction: _____
_____ Reaction: _____

Current Medications & dosage & frequency:
_____
_____
_____
_____

Preferred Pharmacy Used: _____

Please return forms to receptionist with your child's insurance card so that we may make a copy.

Eff. 03/2016