Springtime PEDIATRICS

Patient Registration

Patient Name: _____ **D/O/B**: _____ **Gender**: M/F
First *MI* *Last*

Patient's Address: _____
Address *City* *State* *Zip Code*

Best Phone#: _____

Who does patient live with? ☐ Father ☐ Mother ☐ Both Parents ☐ Shared Parenting ☐ Grandparents ☐ Legal Guardian

Father/Legal Guardian **Responsible for Bills** ☐ **yes** ☐ **no**

Name: _____ D/O/B: _____ PH#: _____ SSN_____

Address: _____ City: _____ State: _____ Zip: _____
Same address as Patient – Circle Here

Occupation: _____ Employer: _____ Work #: _____

Mother/Legal Guardian **Responsible for Bills** ☐ **yes** ☐ **no**

Name: _____ D/O/B: _____ PH#: _____ SSN_____

Address: _____ City: _____ State: _____ Zip: _____
Same address as Patient – Circle Here

Occupation: _____ Employer: _____ Work #: _____

Primary Insurance Information * *Please let the receptionist know if there is more than one insurance covered under the insured*

Subscriber Name: _____ Company: _____

Member ID #: _____ Group#: _____ Insurance #: _____

Emergency Contact Name: _____ Phone #: _____
(*Not living in home*) Relationship to patient: _____

Preferred Language:	**Patient's Ethnicity**: ☐Hispanic/Latino ☐Non-Hispanic/Latino
Patient's Race: ☐AM Indian/AK Native ☐Asian ☐Black/African American ☐Native HI/Pac IS ☐White ☐Prefer not to answer	

Pharmacy: _____
Name *Address* *City* *State* *Zip* *Phone#*

Preferred Email: _____

How did you hear about us? _____

_____ _____ _____
Parent/Guardian Please Print **Signature** **Date**