Springtime PEDIATRICS

Patient Registration

Patient Name _____ DOB _____ Sex: ☐ M ☐ F

Patient's Address _____
Address City State Zip

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

Guarantor (Responsible For Bills)

☐ **Father** ☐ **Mother** ☐ **Other** _____

Name _____

Patient Relationship _____

Address _____
Same As Patient – Circle Here

_____
City State Zip

Best Phone _____

Sec. Phone _____

Mom's Cell _____

Dad's Cell _____

Custodial Parent (Patient Lives With)

☐ **Father** ☐ **Mother** ☐ **Other** _____

Name _____

Patient Relationship _____

Address _____
Same As Patient – Circle Here

_____
City State Zip

Best Phone _____

Sec. Phone _____

Mom's Cell _____

Dad's Cell _____

Primary Insurance

Company _____

Policy # _____

Group # _____

Employer _____

Subscriber Name _____

Choose Patient Relationship to Subscriber:
☐Child ☐Self ☐Other

Secondary Insurance

Company _____

Policy # _____

Group # _____

Employer _____

Subscriber Name _____

Choose Patient Relationship to Subscriber:
☐Child ☐Self ☐Other

Emergency Contact (Not living in home)	Name:
Patient Relationship:	Phone Number:

Preferred Language: _____
Preferred Appt Reminder: ☐ Mom or ☐ Dad or ☐ Guardian
☐ Text / Call Cell ☐ Call 'Best' #
Preferred Email: _____

How Did You Hear About Us?

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

Signed _____ Date _____