Guilford Pediatrics

Patient Registration

Child 1: *Last Name:* _____ *First Name:* _____ *MI:* _____

DOB: ____/ ____/ _____ *Sex:* _____ *Primary Language:* _____

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race:* Asian / Black / Hawaiian / White

Child 2: *Last Name:* _____ *First Name:* _____ *MI:* _____

DOB: ____/ ____/ _____ *Sex:* _____ *Primary Language:* _____

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race:* Asian / Black / Hawaiian / White

Child 3: *Last Name:* _____ *First Name:* _____ *MI:* _____

DOB: ____/ ____/ _____ *Sex:* _____ *Primary Language:* _____

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race:* Asian / Black / Hawaiian / White

Mailing Address:

_____

(Street or PO Box) (City) (State & Zip)

Home Phone: (_____) _____ – _____

Who lives at this household?

_____

Insurance:

Primary Policy: Policy Holder's Name:

_____

Policy Holder's Birth Date: ____/ ____/ _____ *Policy Holder's Sex:*

Insurance Carrier:

ID #: _____ *Group #:* _____

Secondary Policy: Policy Holder's Name:

_____

Policy Holder's Birth Date: ____/ ____/ _____ *Policy Holder's SSN*

Insurance Carrier:

ID #: _____ *Group #:* _____

Parent/Guarantor 1

Name: _____ Relation to Patient: _____

Lives with patient? Yes / No Date of Birth: _____ / _____ / _____

Work Phone: (_____) _____ – _____ Cell Phone: (_____) _____ – _____

Home Email: _____ Work Email: _____

Employer: _____ Occupation: _____

How would you ideally prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Work Phone / Cell Phone

Appointment Reminders: Home Phone / Cell Phone

Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone

Billing Statements: Home Address

General Practice Notices: Home Address / Home Phone / Cell Phone

Parent/Guarantor 2

Name: _____ Relation to Patient: _____

Lives with patient? Yes / No Date of Birth: _____ / _____ / _____

Work Phone: (_____) _____ – _____ Cell Phone: (_____) _____ – _____

Home Email: _____ Work Email: _____

Employer: _____ Occupation: _____

If this contact will need to be notified in addition to Contact 1 for Medical Issues, Appointment Reminders, Recall Notices. Billing Statements, General Practice Notices and Patient Portal Notifications, list their preferences here:

_____

_____

Additional Contact Questions:

Who should receive billing statements?

_____

May all contacts have access to the patent's records electronically? Yes / No

If parents are divorced or separated please fill out this section:

Who has Custody?

_____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment?

Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

_____

Emergency Contacts, *Other than Parents: Name & Relationship*

1. _____ Phone: (_____) _____ – _____

2. _____ Phone: (_____) _____ – _____

Preferred Pharmacy: _____