PATIENT REGISTRATION FORM

(Please Print)

How did you hear about us? ☐ Google ☐ Facebook ☐ Instagram ☐ Hospital

☐ PediaTrust Employee: _____ ☐ Insurance ☐ A Friend ☐ Other: _____

PATIENT INFORMATION

Patient's Last Name: First:	Patient's Cell Ph (if 12 yrs. or older):	Sex: ☐M ☐ F	Birth Date:

Siblings & Birth Dates:	Sibling Name	Nickname	Date of Birth	Patient Cell Ph. (if 12 yrs. or older)

Street address:	City:	State:	Zip Code:

Mother's Name:	Mother's Date of Birth:	Email:

Primary Number: _____ ☐ Home ☐ Cell ☐ Work	Alternate Number: _____ ☐ Home ☐ Cell ☐ Work

Father's Name:	Father's Date of Birth:	Email:

Primary Number: _____ ☐ Home ☐ Cell ☐ Work	Alternate Number: _____ ☐ Home ☐ Cell ☐ Work

If you provide your email, you will be included on occasional important practice announcements via email.

Emergency Contact Name: _____ Emergency Contact Number: _____

☐ Parent ☐ Relative ☐ Friend ☐ Home ☐ Cell ☐ Work

GUARANTOR/ SUBSCRIBER INFORMATION

(PERSON WHO HOLDS THE INSURANCE POLICY)

Guarantor Name:	Relationship to Patient:	Date of Birth:
Guarantor SSN:		

Address (if different from above):	Primary Contact Number (if different from above):

Insurance Company Name:	Insurance ID Number:	Insurance Group Number:	Employer:

Secondary Insurance Company Name (if applicable):	Secondary Insurance ID Number:	Secondary Insurance Group Number:

For Office Use Only:

Pt. Rep. Initials: _____

Date Information Confirmed and Changes Entered: _____

Revised September 2016

Todays Date:

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR BILL)

Guarantor Name:	Relation to Patient:
Email:	

If you provide your email, you will be included on occasional important practice announcements via email.

PATIENT INFORMATION (FILL IN ALL THAT APPLY)

Patient's Last Name:	First:	Middle:	Birth Date:

Ethnicity (please circle):	Not Hispanic or Latino	Hispanic or Latino	Other/Unknown
Race (please circle):	American Indian or Alaska Native	Asian	Black or African American
	Native Hawaiian or Other Pacific Islander	White	Other/Unknown
Preferred Language:			

2nd Patient's Last Name:	First:	Middle:	Birth Date:

Ethnicity (please circle):	Not Hispanic or Latino	Hispanic or Latino	Other/Unknown
Race (please circle):	American Indian or Alaska Native	Asian	Black or African American
	Native Hawaiian or Other Pacific Islander	White	Other/Unknown
Preferred Language:			

3rd Patient's Last Name:	First:	Middle:	Birth Date:

Ethnicity (please circle):	Not Hispanic or Latino	Hispanic or Latino	Other/Unknown
Race (please circle):	American Indian or Alaska Native	Asian	Black or African American
	Native Hawaiian or Other Pacific Islander	White	Other/Unknown
Preferred Language:			

4th Patient's Last Name:	First:	Middle:	Birth Date:

Ethnicity (please circle):	Not Hispanic or Latino	Hispanic or Latino	Other/Unknown
Race (please circle):	American Indian or Alaska Native	Asian	Black or African American
	Native Hawaiian or Other Pacific Islander	White	Other/Unknown
Preferred Language:			

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize PediaTrust or my insurance company to release any information required to process my claims.

Signature: *Date:*

For Office Use Only:

Pt. Rep. Initials: _____

Date Information Confirmed and Changes Entered: _____

Revised September 2016