PATIENT REGISTRATION FORM

(Please Print)

Today's date:			PCP:	
PATIENT INFORMATION				
Patient's last name: First: Middle:			Nick Name:	Patient Cell Ph. (if 12 yrs. or older):
Birth Date:	Age:	Sex: ☐M ☐ F	Siblings & Birth Dates:	
Street address:		City:	State:	Zip Code:
Mother's Name:	Primary Number: ☐ Home ☐ Cell ☐Work		Alternate Number: ☐ Home ☐ Cell ☐Work	Email:
Father's Name:	Primary Number: ☐ Home ☐ Cell ☐ Work		Alternate Number: ☐ Home ☐ Cell ☐ Work	Email:
Ethnicity: (Please circle):	Hispanic or Latino	Not 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/Unkown	
Preferred Language:				
Unless you opt out, we will include you in important practice announcements via email. Opt out? ☐Yes ☐No				
Emergency Contact Name:		Emergency Contact Number:		
☐ Parent ☐ Relative ☐ Friend		☐ Home ☐ Cell ☐ Work		
How did you hear about us?				

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR BILL)			
Guarantor Name:	Relation to Patient:	Birth Date:	Sex: ☐ M ☐ F
Address (if different from above):		Primary Contact Number:	
Employer:	Employer Address:	Employer Phone Number:	

SUBSCRIBER INFORMATION (PERSON WHO HOLDS THE INSURANCE POLICY)			
Subscribers Name (if different from above):	Birth Date:	Sex: ☐ M ☐ F	Social Security Number:
Address (if different from above):		Relation to Patient:	
Employer (if different from above):	Employer Address (if different from above):	Employer Contact Number (if different from above):	
Insurance Company Name:	Type: ☐ PPO ☐HMO ☐ Other:	Policy/ID Number:	
Copay Amount: $	Insurance Company Address:	Group Number:	
Secondary Insurance Company Name:(if applicable)	Type: ☐ PPO ☐HMO ☐ Other:	Policy/ID Number:	
Copay Amount: $	Secondary Insurance Company Address:	Group Number:	
Covered Members Name's and Birth Dates:			

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