SOUTHWEST PEDIATRICS

PATIENT REGISTRATION FORM

Patient: *Last Name*: _____*First Name:* _____*MI*:_____

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

Ethnicity: Hispanic / Non-Hispanic / Unknown / Decline to Answer
Race: Asian / Black / Hawaiian / White /*American Indian / Alaskan Native/ Decline to Answer*

Mailing Address:

_____

(Street) (City) (State) (Zip)

Primary Contact: _____ Phone Number: (_____) _____

Parent 1: *Name:* _____*Relation to Patient:* _____

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

Address: _____

(Street) (City) (State) (Zip)

Cell Phone: (_____) _____ *Work Phone: (_____)* _____

Home Email: _____*Work Email:* _____

Employer: _____ *Occupation:* _____

Parent 2: *Name:* _____*Relation to Patient:* _____

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

Address: _____

(Street) (City) (State) (Zip)

Cell Phone: (_____) _____ *Work Phone: (_____)* _____

Home Email: _____*Work Email:* _____

Employer: _____ *Occupation:* _____

Emergency Contact (other than parents) Name & Relationship:

Name: _____

Address: _____

Phone Number: (_____) _____ Relation: _____

Insurance:

Primary *Policy Holder's Name: _____SSN#_____*

Policy Holder's Birth of Date: _____/_____/_____ *Policy Holder's Sex: Male /Female*

Insurance Carrier: _____

ID #: _____ Group#: _____

Secondary *Policy Holder's Name: _____SSN#_____*

Policy Holder's Birth of Date: _____/_____/_____ *Policy Holder's Sex: Male /Female*

Insurance Carrier: _____

ID #: _____ Group#: _____

WHO IS THE FINANICAL GUARANTOR – If Financial Guarantor is a contact on previous page only complete first line. This is the person that will receive Billing Statements in the mail. (Parents must agree on this and work arrangements out among themselves for payment issues. Southwest Pediatrics cannot become involved with domestic arguments over who receives Billing Statements. If this becomes a recurring problem you may be asked to find another practice that better suits your needs)

Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____/_____/_____ Home Phone _____Cell Phone _____

Do they live with the patient? Yes/ No Name of Employer: _____

Do you have any government issued insurance policies? Yes/ No _____
Which parent would you like our office to contact for patient's medical issues, reminder calls, statements, ECT?
_____

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

Medical Issues': Mail Address / Home Phone / Work Phone / Cell Phone / Home Email / Text to Cell

Appointment Reminders: Text to Cell /Home Phone / Work Phone / Cell Phone / Home Email

Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone / Home Email/Text to Cell

Billing Statements: Home Address / Home Email / Work Email

General Practices Notice: Home Address / Home Phone / Cell Phone / Home Email /Text to Cell

Patient Portal Notifications: Text to Cell / Home Email / Work Email

Contact Privacy Restraints:

Ok to send: text messages/email/fax **Yes/ No**

Additional Questions:

Is child adopted? Yes/ No If so, please provide proof that you are the legal guardian of the patient.

Other Siblings Seen In Our Office: _____

Whom May We Thank, For Referring You Too Our Office? _____