

## REGISTRATION FORM

Today's Date \_\_\_\_\_

Child's Full Legal Name \_\_\_\_\_ Gender M F

Birthdate \_\_\_\_\_ SS # \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Race: B H I M P R S U W

Key: B – Black/African American H – Hispanic I – American Indian/Alaskan Native/Eskimo M – Multi-racial  
P – Pacific Islander R – Refused S – Asian U – Unavailable W – White

Father's Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Mother's Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Email (optional) \_\_\_\_\_

### RESPONSIBLE PARTY IF OTHER THAN PARENT LISTED ABOVE

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Social Security # \_\_\_\_\_ Home Phone # \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone # \_\_\_\_\_

## MEDICAL INSURANCE

Primary Insurance \_\_\_\_\_ Secondary Insurance \_\_\_\_\_

Subscriber \_\_\_\_\_ Subscriber \_\_\_\_\_

ID or Policy # \_\_\_\_\_ ID or Policy # \_\_\_\_\_

Group # \_\_\_\_\_ Plan # \_\_\_\_\_ Group # \_\_\_\_\_ Plan # \_\_\_\_\_

### Brothers/Sisters

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Race \_\_\_\_\_ Gender M F

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Race \_\_\_\_\_ Gender M F

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Race \_\_\_\_\_ Gender M F

All professional services rendered are charged to the parent. Payment is due at time of service unless it is covered by an insurance in which we participate.

I hereby authorize ABC Family Pediatricians to furnish information to insurance carriers concerning my child's illness and treatments.

I also authorize any insurance payment due to the physicians/providers to be paid directly to ABC Family Pediatricians.

Some services, including but not limited to well visits, sports pre-participation physicals, forms completion, after hours phone triage calls, and immunizations may not be covered by my insurance. I understand that I am responsible for any amount not covered by insurance.

Date: \_\_\_\_\_ Parent's Signature: \_\_\_\_\_