KIDZ CARE PEDIATRICS

PATIENT REGISTRATION

CHILD 1: LAST NAME: _____ FIRST NAME: _____ MI:_____

DATE OF BIRTH: _____ SEX: _____ PRIMARY LANGUAGE: _____

ETHNICITY: HISPANIC/ NON-HISPANIC/ UNKNOWN RACE: ASIAN/ BLACK/ HAWAIIAN-PACIFIC/ WHITE

CHILD 2: LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ SEX: _____ PRIMARY LANGUAGE: _____

ETHNICITY: HISPANIC/ NON-HISPANIC/ UNKNOWN RACE: ASIAN/ BLACK/ HAWAIIAN-PACIFIC/ WHITE

CHILD 3: LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ SEX: _____ PRIMARY LANGUAGE: _____

ETHNICITY: HISPANIC/ NON-HISPANIC/ UNKNOWN RACE: ASIAN/ BLACK/ HAWAIIAN-PACIFIC/ WHITE

MAILING ADDRESS: _____

_____

HOME PHONE: _____ CELL PHONE: _____

WHO ALL LIVES AT THIS HOUSEHOLD? _____

PARENT/GUARDIAN 1:

NAME: _____ RELATIONSHIP TO CHILD: _____

DATE OF BIRTH: _____ SSN#: _____ LIVES WITH CHILD? YES / NO

EMPLOYER: _____ OCCUPATION: _____

WORK PHONE: _____ CELL PHONE: _____

PARENT/GUARDIAN 2:

NAME: _____ RELATIONSHIP TO CHILD: _____

DATE OF BIRTH: _____ SSN#: _____ LIVES WITH CHILD? YES / NO

EMPLOYER: _____ OCCUPATION: _____

WORK PHONE: _____ CELL PHONE: _____

MAY BOTH CONTACT HAVE ACCESS TO PATIENT'S RECORDS? **YES / NO**

IF PARENTS ARE DIVORCED OR SEPARATED, PLEASE FILL OUT THE FOLLOWING SECTION:

WHO HAS CUSTODY? : _____

ARE THERE ANY LEGAL RESTRICTIONS THAT PREVENT THE NON-CUSTODIAL PARENT FROM CONSENTING TO MEDICAL TREATMENT FOR THE CHILD OR FROM OBTAINING INFORMATION REGARDING THE CHILD'S MEDICAL TREATMENT?

YES / NO

IF YES, PLEASE EXPLAIN & PROVIDE ANY LEGAL DOCUMENTATION: _____

_____

EMERGENCY CONTACTS (OTHER THAN PARENTS):

NAME: _____ RELATIONSHIP TO CHILD: _____

CONTACT NUMBER: _____

NAME: _____ RELATIONSHIP TO CHILD: _____

CONTACT NUMBER: _____

INSURANCE:

INSURANCE PLAN: _____ MEMBER ID NUMBER: _____

WHO SHOULD RECEIVE BILLING STATEMENTS? _____

PHARMACY INFORMATION:

PHARMACY NAME: _____ LOCATION: _____

PHONE NUMBER: _____