

Brownsboro Park Pediatrics

PATIENT REGISTRATION YEARLY UPDATE

Patient Name (First, MI, Last) _____ Date of Birth _____

Preferred Name _____ Gender _____ Male _____ Female

Address _____

City _____ State _____ Zip _____

Race _____ Ethnicity: NON-HISPANIC HISPANIC DECLINE TO ANSWER (Circle One)

Primary Language Spoken In the Home _____

Pharmacy _____ Pharmacy Address _____

Emergency Contact (Outside of the Home) _____ Phone _____

Other Children in the Home That Are Patients of This Practice _____

GUARANTOR/RESPONSIBLE PARTY INFORMATION

Name _____

Name _____

Relationship to Child _____

Relationship to Child _____

DOB _____ SSN _____ - _____ - _____

DOB _____ SSN _____ - _____ - _____

Address (If different than patient)

Address (If different than patient)

Phone# _____ Cell _____ Home _____

Phone# _____ Cell _____ Home _____

Is it ok to leave a message at the above numbers? ___ Yes ___ No

Email _____

Email _____

Employer _____

Employer _____

If Parents Are Divorced or Separated, Please Complete The Following Section.

Who Has Primary Custody? _____ Please supply court documents.

Are there any legal restrictions that would keep the non-custodial parent from consenting to medical treatment or from obtaining information about the child's medical treatment? ____ Yes ____ No

If yes, please explain, and provide our office a copy of any legal documents that support the restrictions

INSURANCE INFORMATION

Primary Insurance _____ Employer _____

Member/Subsriber ID# _____ Group _____

Subscriber's Name _____ DOB _____

Subscriber's SSN _____ Relationship to Patient _____

Secondary Insurance _____ Employer _____

Member/Subsriber ID# _____ Group _____

Subscriber's Name _____ DOB _____

Subscriber's SSN _____ Relationship to Patient _____

Signature _____ Today's Date _____