PEDS

primarycare
HEALTH PARTNERS

PATIENT REGISTRATION FORM

Please fill out both sides of this form as completely as possible.

Section 1: PATIENT INFORMATION

Name: _____
Last First Middle

Other names used (nickname): _____

SSN: _____ Date of Birth: _____ Gender: M F

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Declined

Race:
- ☐ Black, African American
- ☐ Asian
- ☐ White
- ☐ American Indian, Alaska Native
- ☐ Native Hawaiian, Other Pacific Islander
- ☐ Declined

Primary Language spoken: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone #s Home: _____ Cell: _____

Email: _____

Mother's Maiden Name: _____

Custody: ☐ Parents ☐ Mother ☐ Father ☐ Other: _____

Primary Care Physician (PCP): _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient: _____

Phone #s Home: _____ Work: _____

OTHER SIBLINGS/HOUSEHOLD MEMBERS

Name	DOB	Lives in Household?	Name	DOB	Lives in Household?
		Y N			Y N
		Y N			Y N
		Y N			Y N
		Y N			Y N
		Y N			Y N
		Y N			Y N

CONTINUE, PLEASE FILL OUT PAGE 2 ▸

Section 2: PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN #1

Name: _____ (Last) _____ (First) Relationship to patient: _____

SSN: _____ Date of Birth: _____ Gender: M F

Marital Status: ☐ Single ☐ Married ☐ Civil Union ☐ Divorced

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone #s Home: _____ Cell: _____ Work: _____

Email: _____ Occupation: _____

PARENT/GUARDIAN #2

Name: _____ (Last) _____ (First) Relationship to patient: _____

SSN: _____ Date of Birth: _____ Gender: M F

Marital Status: ☐ Single ☐ Married ☐ Civil Union ☐ Divorced

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone #s Home: _____ Cell: _____ Work: _____

Email: _____ Occupation: _____

Section 3: INSURANCE INFORMATION

PRIMARY INSURANCE

Name: _____ Effective Date of Coverage: _____

Claims Address: _____

City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____

SUBSCRIBER INFORMATION Name: _____ (Last) _____ (First)

SSN: _____ Date of Birth: _____ Gender: M F

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

SECONDARY INSURANCE

Name: _____ Effective Date of Coverage: _____

Claims Address: _____

City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____

SUBSCRIBER INFORMATION Name: _____ (Last) _____ (First)

SSN: _____ Date of Birth: _____ Gender: M F

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

ASSIGNMENT OF INSURANCE BENEFITS/Authorization of Release Records

I hereby authorize Primary Care Health Partners to recover from my insurance payment for any services Primary Care Health Partners provides to me. I understand that I am financially responsible for all charges not covered by insurance. I hereby authorize Primary Care Health Partners to release all information necessary to secure such payments. A photocopy of this statement is to be considered as valid as the original.

Signed: _____ Date: _____