BUCKINGHAM PEDIATRICS

PATIENT REGISTRATION

CHILD 1: Last Name: _____First Name: _____ MI:_____

D.O.B.:_____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non- Hispanic Declined to specify Race: American Indian/Alaskan Native/Asian/African American/Hawaiian/White

CHILD 2: Last Name: _____First Name: _____ MI:_____

D.O.B.:_____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non- Hispanic Declined to specify Race: American Indian/Alaskan Native/Asian/African American/Hawaiian/White

CHILD 3: Last Name: _____First Name: _____ MI:_____

D.O.B.:_____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non- Hispanic Declined to specify Race: American Indian/Alaskan Native/Asian/African American/Hawaiian/White

Primary Phone # _____ (circle one) Home or Cell specify other _____

Mailing Address:

_____

(Street or PO Box) (City) (State &Zip)

Who lives at this household?_____

Insurance:

Primary Policy: Policy Holder's Name:_____SS#_____

Policy Holder's Date of Birth:_____/_____/_____ Sex: _____ Relationship to Patient:_____

Insurance Carrier:_____Effective date of coverage_____

ID#:_____Group#:_____

Secondary Policy: Policy Holder's Name:_____SS#_____

Policy Holder's Date of Birth:_____/_____/_____ Sex: _____ Relationship to Patient:_____

Insurance Carrier:_____Effective date of Coverage_____

ID#:_____Group#:_____

Signature on file. I authorize use of this form on all my insurance submissions. I permit a copy of this to be used in place of the original. I authorize release of information to all my Insurance Carriers. I understand that I am responsible for my bills. I agree to the practice charging my credit card on file or charging my credit card with my verbal permission. PLEASE REMEMBER TO ADD YOUR NEWBORN TO YOUR INSURANCE POLICY

SIGNATURE OF PARENT/GUARDIAN /CONTACT 1_____DATE_____

SIGNATURE OF PARENT/GUARDIAN /CONTACT 2_____DATE_____

Contact 1: _____ Relationship to Patient :_____

Lives with Patient? Yes / No (If no please complete with address)

_____

(Street or PO Box) (City) (State &Zip)

Date of Birth: _____ / _____/ _____ Work Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Home Email: _____ Work Email:_____

Employer:_____ Occupation:_____

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

Medical Issues: Home Phone / Work Phone / Cell Phone

Appt. Reminders: Home Phone / Cell Phone

Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone

Billing Stmts.: Home Address

Patient Portal Notifications: Home Phone / Cell Phone / Home Email / Work Email

Contact 2: _____ Relationship to Patient :_____

Lives with Patient? Yes / No (If no please complete with address)

_____

(Street or PO Box) (City) (State &Zip)

Date of Birth: _____ / _____/ _____ Work Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Home Email: _____ Work Email:_____

Employer:_____ Occupation:_____

If this contact will need to be notified in addition to contact 1 for Medical Issues, Appointment Reminders, Recall Notices, Billing Statements, General Practice Notices and Patient Portal Notifications list their preference here: _____

_____

_____

Additional Contact Questions:

Who should receive billing statements: _____

May all contacts have access to the patient's records electronically Yes / No :_____

If parents are divorced or separated please fill out this section:

Who has Physical and Legal Custody? _____

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

If yes please explain and provide a copy of any legal paperwork that supports this restriction: _____

_____

Emergency Contacts, other than parents: Name & Relationship

*1:*_____ *Phone (____)* _____

*2:*_____ *Phone (____)* _____