LOUDON PEDIATRIC CLINIC

PATIENT REGISTRATION

DATE:_____

CHILD 1: Last Name:_____First Name:_____MI:_____

D.O.B. ____/____/____ Sex: Male / Female SSN#____-____-____

Mailing Address:

_____**Home Phone (** **)**_____-_____

City_____**Day Phone (** **)**_____-_____

State_____**Zip Code**_____**Cell Phone (** **)**_____-_____

Emergency Contact: (OTHER THAN PARENTS)

Name:_____Relationship:_____Phone: (_____)_____

Primary Language:_____

Ethnicity: Hispanic / Non-Hispanic / Unknown **Race:** American Indian / Asian / Black / Hawaiian / White

Contact 1: Mother / Father / Legal Guardian (CIRCLE ONE)

Name:_____ Lives with patient? Yes / No

Mailing Address:_____

City_____State_____Zip Code_____

SSN#:____-____-____ Date of Birth:____/____/____

E-Mail :_____

Home Phone: (_____)_____-_____Cell Phone: (_____)_____-_____

Work Phone: (_____)_____-_____Employer:_____

How would you prefer to be contacted regarding the following? Please circle your answers:

Medical issues: Home Address / Home Phone / Work Phone / Cell Phone / Text to Cell / Home Email

Appointment Reminders: Home Address / Home Phone / Work Phone / Cell Phone / Text to Cell / Home Email

Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone / Text to Cell / Home Email

Billing Statements: Home Address / Text to Cell / Home Email / Work Email

General Practice Notices: Home Address / Home Phone / Work Phone / Cell Phone / Text to Cell / Home Email

Patient Portal Notifications: Text to Cell / Home Email / Work Email

PLEASE COMPLETE BACK OF FORM

Contact 2: Mother / Father / Legal Guardian (CIRCLE ONE)

Name:_____Lives with patient? Yes / No

Mailing Address:_____

City_____State_____Zip Code_____

SSN#:_____-_____-_____Date of Birth:_____/_____/_____

E-Mail:_____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Work Phone:(_____)_____-_____Employer:_____

Who should receive billing statements?_____

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

Who has custody?_____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining 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. _____

Insurance:

Primary Policy: Policy Holder's Name:_____

Policy Holder's Birth Date:_____Policy Holder's SSN:_____

Insurance Carrier:_____

ID#_____**Group#**_____

Secondary Policy: Policy Holder's Name:_____

Policy Holder's Birth Date:_____Policy Holder's SSN:_____

Insurance Carrier:_____

ID#_____**Group#**_____

CHILD 2: Last Name:_____First Name:_____MI:_____

D.O.B._____/_____/_____Sex: M / F SSN#_____-_____-_____ Primary Language:_____

Ethnicity: Hispanic / Non-Hispanic / Unknown **Race:** American Indian / Asian / Black / Hawaiian / White

CHILD 3: Last Name:_____First Name:_____MI:_____

D.O.B._____/_____/_____Sex: M / F SSN#_____-_____-_____ Primary Language:_____

Ethnicity: Hispanic / Non-Hispanic / Unknown **Race:** American Indian / Asian / Black / Hawaiian / White