PREMIER Pediatrics

Patient Registration Form

Patient

Please register all patients to be seen at Premier Pediatrics. Additional registration space is available on page 2.

Patient # 1: _____ _____

Legal Name (First, MI, Last) **Alternate Name**

__/__/__ **Date of Birth**

Sex: ☐ Male ☐ Female

Pediatrician: ☐ Winburn-Antovoni ☐ Bush ☐ Jensen ☐ Hadley

Resides With: ☐ Primary Contact ☐ Secondary Contact

Family Info

Please provide the primary contact information for your family.

Home Address Street Apt. # City State Zip

Main Family Phone Number: ( ) -

Preferred Contact Number: ( ) -

Family Email Address: _____

Referred By: _____

Primary Contact

Please provide contact information for the party who is financially responsible for the patient (i.e. this will most often be a parent).

Relationship to Patient(s): ☐ Mother (Genetic) ☐ Father (Genetic) ☐ Other: _____

_____ - - _____

Legal Name (First, MI, Last) **Social Security Number**

__/__/__ **Date of Birth** ( ) - **Work Number** ( ) - **Cell Phone** _____ **Employer**

☐ *Same as family address*

Home Address Street Apt. # City State Zip

Secondary Contact

Please provide contact information for an alternate responsible party (i.e. most often this will be a parent).

Relationship to Patient(s): ☐ Mother (Genetic) ☐ Father (Genetic) ☐ Other: _____

_____ - - _____

Legal Name (First, MI, Last) **Social Security Number**

__/__/__ **Date of Birth** ( ) - **Work Number** ( ) - **Cell Phone** _____ **Employer**

☐ *Same as family address*

Home Address Street Apt. # City State Zip

Additional Emergency Contact: _____ *(Contact should be in addition to parent(s) listed above.)*

Phone Number: ( ) - ☐ Home ☐ Work ☐ Cell **Relationship:** _____

Insurance

*Please present the front office staff with the patient's insurance card **in addition to** completing the following information.*

Primary Insurance Company: _____ **Policy Holder:** _____

Children on this Plan: _____ **Co-pay:** _____

Is the **Primary Policy Holder** listed as one of the contacts on pg 1? ☐ Yes ☐ No *(If **NO**, please complete the alternate contact information on pg 2)*

Do any patients have a **Secondary Insurance Plan**? ☐ Yes ☐ No *(If **YES**, please provide this information to the front office staff.)*

Please turn this form over and continue on page 2…

Preferences

Preferred Contact Methods:

Medical Issues: ☐ Home/Primary Phone ☐ Work Phone ☐ Cell Phone

Reminder Text: ☐ **Cell Phone - Parent Name** _____ **#**_____

if multiple texts req'd. ☐ **Cell Phone - Parent Name** _____ **#**_____

Recalls: ☐ Home/Primary Phone ☐ Work Phone ☐ Cell Phone

Billing Statements: ☐ Family Mail Address ☐ Other Address:

General Notices: ☐ Family Mail Address ☐ Family/Home Email ☐ Other Address:

Demographic Information:

Primary Language: ☐ Decline to Answer ☐ English ☐ Other:

Ethnicity: ☐ Decline to Answer ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ Decline to Answer ☐ American Indian/Alaskan Native ☐ Asian
☐ Black ☐ Hawaiian Native/Pacific Islander ☐ White

Thank you for taking the time to fill this form out ***completely*** *! Additional registration space can be found below. Please be sure to read and sign the* ***Financial Policy/Consent to Treat*** *included in this packet. The* ***Privacy Policy*** *is yours to keep. Please return all completed forms to the front office staff.*

Additional Patient Registration

If you have other children who have the ***SAME*** *contact information as Patient # 1, please continue below, registering all patients to be seen at Premier Pediatrics . However, please note that we do need complete information for* ***EACH*** *child, including contact information for* ***ALL*** *legal guardians. If you need to register an additional paitent who has a different legal guardian or other contact information, please complete a* ***SEPERATE*** *registration form for this child.*

Patient # 2: _____ _____

Legal Name (First, MI, Last) **Alternate Name**

/ / **Sex:** ☐ Male ☐ Female **Pediatrician:** ☐ Winburn-Antovoni ☐ Bush ☐ Jensen ☐ Hadley **Resides With:** ☐ Primary Contact ☐ Secondary Contact

Date of Birth

Patient # 3: _____ _____

Legal Name (First, MI, Last) **Alternate Name**

/ / **Sex:** ☐ Male ☐ Female **Pediatrician:** ☐ Winburn-Antovoni ☐ Bush ☐ Jensen ☐ Hadley **Resides With:** ☐ Primary Contact ☐ Secondary Contact

Date of Birth

Patient # 4: _____ _____

Legal Name (First, MI, Last) **Alternate Name**

/ / **Sex:** ☐ Male ☐ Female **Pediatrician:** ☐ Winburn-Antovoni ☐ Bush ☐ Jensen ☐ Hadley **Resides With:** ☐ Primary Contact ☐ Secondary Contact

Date of Birth

Alternate Contact

If you feel that our office should have an alternate contact on file, please provide this information below.

Relationship to Patient(s): ☐ Stepmother ☐ Stepfather ☐ Custodial Grandparent ☐ Other _____

_____ - - _____

Legal Name (First, MI, Last) **Social Security Number**

/ / ( ) - ( ) - _____

Date of Birth **Work Number** **Cell Phone** **Employer**

☐ *Same as family address*

Home Address Street Apt. # City State Zip