PROSPECT PEDIATRICS PSC

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PATIENT REGISTRATION

Child's Last Name:________________________ First Name:____________________ MI:______
Name Child Likes to be Called:____
Sex:________ Date of Birth:_______________ Patient's Social Security #:_______________
Additional Children:____
Name Child Likes to be Called:____
Sex:____________________ Date of Birth(s):______________________________________
Patient's Social Security #(s):____
Mailing (Billing) Address:

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

Primary Language Spoken in the Home: ______________________________
Ethnicity: (Circle one) Hispanic Non-Hispanic Decline to Answer
Race: (circle all that apply) American Indian Asian Black Hawaiian Native White

Contact Numbers / Emails:
Patients: Primary Phone:________________________ Cell Phone:__________________

Parent 1: Name:____________________________ Date of Birth:__________________
Social Security #:____
Work Phone:__________________________ Cell Phone:__________________________
Personal Email:__________________________ Work Email:__________________________
Employer:____
Lives with patient? (circle one) Yes No Relationship to Patient:______________________

Parent 2: Name:____________________________ Date of Birth:__________________
Social Security #:____
Work Phone:__________________________ Cell Phone:__________________________
Personal Email:__________________________ Work Email:__________________________
Employer:____
Lives with patient? (circle one) Yes No Relationship to Patient:______________________

Emergency Contact (other than parents): Name and Relationship
1:____ Phone:____________________
2:____ Phone:____________________
3:____ Phone:____________________
4:____ Phone:____________________

Insurance:

Primary Insurance: ____________________

Policy Holder's Last Name:__________ First Name:__________ MI:_____

Policy Holder's Date of Birth:__________ Social Security #:__________

ID #:__________ Group #:__________

Secondary Insurance: ____________________

Policy Holder's Last Name:__________ First Name:__________ MI:_____

Policy Holder's Date of Birth:__________ Social Security #:__________

ID #:__________ Group #:__________

Billing Statements Sent To (if different from above):

Name:__________ Social Security #:__________

Relationship to Patient:__________

Address:__________

Primary Phone:__________ Cell Phone:__________

Privacy Constraints (check one):

____ No Restrictions: Okay to leave message / send mail.

____ Restrictions: Person to person with patient / guardian only.

____ Restrictions: ____________________

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

Medical Issues: Home Phone Work Phone Cell Phone Home Email

Appointment Reminders: Home Phone Cell Phone Home Email Work Email

Recall: Home Address Home Phone Work Phone Cell Phone Home Email

Billing Statements: Home Address Home Email Work Email

General Notices: Home Address Home Phone Work Phone Cell Phone Home Email

Patient Portal: Cell Phone Home Email Work Email

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 treatments? _____ Yes _____ No

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

____

I authorize the release of any medical or other information necessary to process claims from Prospect Pediatrics. I also request payment of government benefits either to myself or to the party who accept assignment below.

Signature:____________________ Date:__________