KID CARE PEDIATRICS

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KidCarePeds.com

Patient Registration Form

Today's Date: _____

PATIENT'S NAME: _____
FIRST M LAST

DATE OF BIRTH:_____ M/F_____

SIBLINGS

NAME:_____ DATE OF BIRTH:_____/_____/_____ M/F:_____

NAME:_____ DATE OF BIRTH:_____/_____/_____ M/F:_____

NAME:_____ DATE OF BIRTH:_____/_____/_____ M/F:_____

NAME:_____ DATE OF BIRTH:_____/_____/_____ M/F:_____

PARENT/GUARDIAN #1

LAST NAME: _____ FIRST NAME:_____ MIDDLE INITIAL:_____

DATE OF BIRTH:_____ RELATIONSHIP TO PATIENT:_____

HOME ADDRESS:_____CITY_____STATE:_____ ZIP_____

HOME PHONE:_____ WORK PHONE:_____ CELL PHONE:_____

EMPLOYER_____JOB TITLE_____

MOTHER'S MAIDEN NAME:_____ EMAIL:_____

PARENT/GUARDIAN #2

LAST NAME: _____ FIRST NAME:_____ MIDDLE INITIAL:_____

DATE OF BIRTH:_____ RELATIONSHIP TO PATIENT:_____

HOME ADDRESS:_____CITY_____STATE:_____ ZIP_____

HOME PHONE:_____ WORK PHONE:_____ CELL PHONE:_____

EMPLOYER_____JOB TITLE_____

EMAIL: _____

PATIENT LIVES WITH:_____

EMERGENCY CONTACT: Name_____ Relationship to Patient _____

Phone #:_____

KID CARE PEDIATRICS

Primary Insurance Information

Insurance Company Name:		ID Number:	Group Number:
Policyholder's Name:		Date of Birth:	Social Security Number:
Employer Name:		Work Telephone Number:	
Employer's Address:	City/Town:	State:	Zip Code:

Secondary Insurance Information

Insurance Company Name:		ID Number:	Group Number:
Policyholder's Name:		Date of Birth:	Social Security Number:
Employer Name:		Work Telephone Number:	
Employer's Address:	City/Town:	State:	Zip Code:

HOW DID YOU HEAR ABOUT OUR PRACTICE?_____

☐ (**Please check**) I authorize treatment of the patient named above, and all siblings listed, by Kid Care Pediatrics. I authorize the release of medical records necessary to process insurance claims and to other medical providers involved in my child's/children's care. I authorize payment of medical benefits to be made directly to Kid Care Pediatrics.

☐ (**Please check**) I have been presented with a copy of the Notice of Privacy Practices for the office of Kid Care Pediatrics detailing how my information may be used and disclosed as permitted under federal and state law.

Signature _____ Date _____ /_____ / _____

Name (Print) _____ Relationship to patient _____