

PATIENT REGISTRATION FORM

(Please Print)



How did you hear about us? <input type="checkbox"/> Google <input type="checkbox"/> Facebook <input type="checkbox"/> Instagram <input type="checkbox"/> Hospital				
<input type="checkbox"/> PediaTrust Employee: _____ <input type="checkbox"/> Insurance <input type="checkbox"/> A Friend <input type="checkbox"/> Other: _____				
PATIENT INFORMATION				
Patient's Last Name:		First:	Patient's Cell Ph (if 12 yrs. or older):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F Birth Date:
Siblings & Birth Dates:	Sibling Name		Nickname	Date of Birth Patient Cell Ph. (if 12 yrs. or older)
Street address:			City:	State: Zip Code:
Mother's Name:		Mother's Date of Birth:		Email:
Primary Number: _____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work			Alternate Number: _____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
Father's Name:		Father's Date of Birth:		Email:
Primary Number: _____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work			Alternate Number: _____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
If you provide your email, you will be included on occasional important practice announcements via email.				
Emergency Contact Name: _____			Emergency Contact Number: _____	
<input type="checkbox"/> Parent <input type="checkbox"/> Relative <input type="checkbox"/> Friend			<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	

GUARANTOR/ SUBSCRIBER INFORMATION			
(PERSON WHO HOLDS THE INSURANCE POLICY)			
Guarantor Name:		Relationship to Patient:	Date of Birth:
Guarantor SSN:			
Address (if different from above):			Primary Contact Number (if different from above):
Insurance Company Name:	Insurance ID Number:	Insurance Group Number:	Employer:
Secondary Insurance Company Name (if applicable):	Secondary Insurance ID Number:	Secondary Insurance Group Number:	

For Office Use Only:

Pt. Rep. Initials: _____

Date Information Confirmed and Changes Entered: _____

Revised September 2016



Today's Date: _____

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR BILL)

Guarantor Name:	Relation to Patient:
Email:	
If you provide your email, you will be included on occasional important practice announcements via email.	

PATIENT INFORMATION (FILL IN ALL THAT APPLY)

Patient's Last Name:	First:	Middle:	Birth Date:
Ethnicity (please circle):	Not Hispanic or Latino	Hispanic or Latino	Other/Unknown
Race (please circle):	American Indian or Alaska Native	Asian	Black or African American
	Native Hawaiian or Other Pacific Islander	White	Other/Unknown
Preferred Language:			

2nd Patient's Last Name:	First:	Middle:	Birth Date:
Ethnicity (please circle):	Not Hispanic or Latino	Hispanic or Latino	Other/Unknown
Race (please circle):	American Indian or Alaska Native	Asian	Black or African American
	Native Hawaiian or Other Pacific Islander	White	Other/Unknown
Preferred Language:			

3rd Patient's Last Name:	First:	Middle:	Birth Date:
Ethnicity (please circle):	Not Hispanic or Latino	Hispanic or Latino	Other/Unknown
Race (please circle):	American Indian or Alaska Native	Asian	Black or African American
	Native Hawaiian or Other Pacific Islander	White	Other/Unknown
Preferred Language:			

4th Patient's Last Name:	First:	Middle:	Birth Date:
Ethnicity (please circle):	Not Hispanic or Latino	Hispanic or Latino	Other/Unknown
Race (please circle):	American Indian or Alaska Native	Asian	Black or African American
	Native Hawaiian or Other Pacific Islander	White	Other/Unknown
Preferred Language:			

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize PediaTrust or my insurance company to release any information required to process my claims.

Signature: _____ *Date:* _____

For Office Use Only:

Pt. Rep. Initials: _____

Date Information Confirmed and Changes Entered: _____

Revised September 2016