Patient Registration

Child 1 - Last name:_____ First name_____ MI:____ Sex_____ DOB:_____
Primary Language:_____
Ethnicity: Hispanic/Non-Hispanic/Unknown
Race: White/Black/Hawaiian/Asian

Child 2- Last name:_____ First name_____ MI:____ Sex_____ DOB:_____
Primary Language:_____
Ethnicity: Hispanic/Non-Hispanic/Unknown
Race: White/Black/Hawaiian/Asian

Child 3 - Last name:_____ First name_____ MI:____ Sex_____ DOB:_____
Primary Language:_____
Ethnicity: Hispanic/Non-Hispanic/Unknown
Race: White/Black/Hawaiian/Asian

Child 4 - Last name:_____ First name_____ MI:____ Sex_____ DOB:_____
Primary Language:_____
Ethnicity: Hispanic/Non-Hispanic/Unknown
Race: White/Black/Hawaiian/Asian

Mailing Address:
Street:_____City:_____State:_____Zip_____
Primary Phone:_____

Billing Address (if different from mailing address):
Street:_____City:_____State:_____Zip_____
Primary Phone:_____

Insurance:
Primary Insurance Carrier:_____ID#_____Group#_____
Primary Insurance Policy Holder:
Last name:_____ First name_____MI:____Sex_____DOB:_____SS#_____

Secondary Insurance Carrier:_____ID#_____Group#_____
Secondary Insurance Policy Holder:
Last name:_____ First name_____MI:____Sex_____DOB:_____SS#_____

I hereby assign all medical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all charges not paid by insurance. I hereby voluntarily consent to treatment at Stepping Stones Pediatrics and authorize such treatments, examinations, medications, and diagnostic procedures (including, but not limited to the use of lab and radiographic studies as ordered by attending physicians).

Signature of Parent or Legal Guardian: _____Date:_____

CONTACTS

Parent Contact 1:

Last name: _____ First name_____ MI: _____

Sex_____ DOB: _____SS#_____

Relationship to patient: _____ Resides With Patient?_____

Employer:_____Occupation:_____

Primary Phone:_____ Secondary Phone:_____

Primary Email:_____ Secondary Email:_____

NOTIFICATIONS: How would you prefer to be contacted regarding the following (check one):
Medical issues: Primary Phone _____ Secondary Phone _____
Appointment Reminders: Primary Phone _____ Secondary Phone _____

Parent Contact 2:

Last name: _____ First name_____ MI: _____

Sex_____ DOB : _____SS#_____

Relationship to patient:_____ Resides With Patient?_____

Employer:_____Occupation:_____

Primary Phone:_____ Secondary Phone:_____

Primary Email:_____ Secondary Email:_____

NOTIFICATIONS: How would you prefer to be contacted regarding the following (circle one):
Medical issues: Primary Phone _____ Secondary Phone _____
Appointment Reminders: Primary Phone_____ Secondary Phone_____

Additional Contact Questions:
Which of the provided contacts should receive billing statements? _____
Should both of the provided contacts be able to access patient's records electronically? _____
If not, please specify which of the above contacts should be given access. _____

EMERGENCY CONTACTS: (other than parents)

1: Name:_____Relationship:_____Phone:_____

2: Name:_____Relationship:_____Phone:_____

3: Name:_____Relationship:_____Phone:_____

4: Name:_____Relationship:_____Phone:_____

IF PARENTS ARE DIVORCED OR SEPARATED, PLEASE FILL OUT THIS SECTION:
Who has custody of the child/children? _____
Are there any legal considerations that might restrict the non-custodial parent from consenting to medical treatment?
YES_____NO_____
If yes, please explain and provide legal documentation that supports that restriction_____
_____
_____