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______________________________

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