HELPING HANDS PEDIATRICS

PEDIATRIC PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Last Name: ___________________________ First Name: ____________________ Middle Name: ____________

SS#: _____________________ Sex (circle): Male Female Date of Birth: _______________

Address: _____________________________________ City: __________________ State: _____ Zip: ___________

Phone #:_______________________ Additional Phone #: _________________________

Emergency Contact Name: ___________________________ Emergency Phone #: ________________________

PARENT INFORMATION:

** Person responsible for bill:

Last Name: ___________________________ First Name: ____________________ Middle Name: ____________

SS#: _____________________ Sex (circle): Male Female Date of Birth: _______________

Address (if different from above): ____

**Mother's First & Last Name: ____________________________ DOB: _______________ SS#: ______________
Mother's Phone #: ____________________ Mother's Additional Phone #: _______________________

**Father's First & Last Name: ____________________________ DOB: _______________ SS#: ______________
Father's Phone #: ____________________ Father's Additional Phone #: _______________________

Please provide names of siblings: ____

INSURANCE INFORMATION:

Policy Holder's Name: ___________________________ Insurance Name: _______________________________

Policy Holder's SS#: _____________________ Policy Holder's Date of Birth: _______________

Policy / ID #: _____________________________________ Group: __________________

Insurance Claims Address & Phone #: ____

SECONDARY INSURANCE:

Policy Holder's Name: ___________________________ Insurance Name: _______________________________

Policy Holder's SS#: _____________________ Policy Holder's Date of Birth: _______________

Policy / ID #: _____________________________________ Group: __________________

Insurance Claims Address & Phone #: ____

** Required Fields

Please provide copies of insurance cards in addition to completing all information on this form.