# Paradise Pediatrics, PL

**3400 Bee Ridge Rd., Suite 120, Sarasota, Fl 34239**
**Phone: 941-924-9900 Fax: 941-924-9919**

## PATIENT REGISTRATION FORM

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

| | | | | |
|---|---|---|---|---|
| Patient Name ( Last, First) | Today's Date | Date of Birth | Sex | Age |
| Siblings ( Last, First) | | Date of Birth | Sex | Age |
| Siblings ( Last, First) | | Date of Birth | Sex | Age |
| Mother's Name | Father's name | | | |
| Mother's Social Security Number /Date of Birth | Father's Social Security Number /Date of Birth | | | |
| Home Address | City | State | Zip | |
| Mailing Address if Different | City | State | Zip | |
| Home Phone Number | Work Phone Number | Cell Phone Number | | |
| Email Address: | | | | |
| Occupation | Employer's Name | | | |
| Employer's Address | City | State | Zip | Phone |
| Demographics : Preferred Language: | | Ethnicity : Hispanic [ ] Non- Hispanic [ ] | | |
| Race: | Asian [ ] Black [ ] Caucasian [ ] | Hispanic [ ] Native American [ ] | | |
| Previous Physician's Name: | Whom May We Thank for Referring You to Our Practice? | | | |
| **NOTIFY IN CASE OF EMERGENCY** | | | | |
| Name | Relationship | | | |
| Address | City | State | Zip | |
| Home Telephone Number | Work Telephone Number | Cell Phone Number | | |
| Nearest Relative (not living with your) | | | | |
| Home Telephone | Work Telephone | | | |
| **FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES** | | | | |
| Name | Telephone | | | |
| Address | City | State | Zip | |
| Insurance Company | Claim Address | | | |
| Subscriber's Name | Subscriber's Date of Birth | Subscriber's SSN#. | | |
| Insurance ID No.: | | | | |
| Secondary Insurance (Medicaid not accepted as secondary) | Claim Address | | | |
| Subscriber's Name | Subscriber's Date of Birth | Subscriber's SSN# | | |

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