PARADISE PEDIATRICS

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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. TODAY'S DATE: _____

Patient Name (Last, First, Initial)	Date of Birth	Sex	Age
Siblings (Last, First)	Date of Birth	Sex	Age
Siblings (Last, First)	Date of Birth	Sex	Age
Mother's Name:	Date of Birth	Social Security Number	
Home Address:			
Mailing Address if different:			
Home Phone:	Cell:	Work:	
Occupation:	Employer:		
Father's Name:	Date of Birth	Social Security Number	
Home Address:			
Mailing Address if different:			
Home Phone:	Cell:	Work:	
Occupation:	Employer:		
Demographics: Preferred Language:	Ethnicity: [ ] Hispanic	[ ] Non-Hispanic	
Race: [ ] Asian [ ] Black [ ] Caucasian [ ] Hispanic [ ] Native American [ ] Other [ ] Unknown/Refuse to Answer			
E-mail address:			
Whom may we thank for referring you to our office?			
Previous Pediatrician Name:			
NOTIFY IN CASE OF EMERGENCY:			
Name:	Phone:	Relationship:	
Name:	Phone:	Relationship:	
Nearest Relative not living with you:	Phone:		
FINANCIAL INFORMATION – PERSON RESPONSIBLE FOR FEES IF DIFFERENT FROM PARENTS			
Name:	Phone:		
Address:			
INSURANCE COMPANY:	**ID**:		
Subscriber's Name:	Subscriber Date of Birth:	Subscriber SSN:	
Insurance Claim Address:			
WE DO NOT FILE SECONDARY INSURANCE BUT WILL PROVIDE YOU WITH A CLAIM FORM SO YOU MAY FILE ON YOUR OWN BEHALF.			