The Pediatric Place

PATIENT REGISTRATION

Last Name: _____
First Name: _____
Address: _____
City, State, Zip:

_____
Home Phone: _____
Work Phone: _____
Mobile Phone: _____
Sex *(circle one)*: Male Female Other
Date of Birth: _____
Social Security No: *(optional)*_____
Email: _____
Language: _____
Race: [ ] White [ ] American Indian [ ] Asian [ ] Asian Indian
[ ] Pacific Islander [ ] Black/African American [ ] Other _____
Ethnicity: [ ] Hispanic or Latino [ ] Non Hispanic or Latino
Patient Marital Status: _____

Guarantor Information *(to whom statements are sent)*
Name: _____
Address *(if different from patient)*: _____
City, State, Zip:

_____
Relationship to patient: _____
Date of Birth: _____
Social Security No: *(optional)* _____
Phone: _____

Emergency Contact
Name: _____
Relationship to patient: _____
Phone: _____

Preferred Pharmacy Name: _____
Preferred Pharmacy City: _____

Insurance Policy Holder *(if different from guarantor)*
Name: _____
Date of Birth: _____
Relationship to patient: _____