Patient Registration

Patient

First Name: ____________________ Last Name: _________________ Middle Initial: _____

Preferred Name if any: _________________ Date of Birth: ___________________

Biological Gender: Male/Female Preferred Gender if any: __________________

Street Address: ______________________ City: ________________ State: ___ Zip: ________

Home Phone: _____________________ Preferred Language: ________________

Race: __Caucasian __Black or African American__ Asian __ Native American or American Indian __Alaskan Native or Native Hawaiian __ Other Pacific Islander __Other__ Decline to answer

Ethnicity: __Hispanic or Latino __ Non-Hispanic or non-Latino__ Decline to answer

Parent/Legal Guardian

First Name: ____________________ Last Name: _________________ Middle Initial: _____

Preferred Name or Other Names used if any: _________________

Date of Birth: ___________________

Relationship to Patient: __ Mother __ Father __Stepmother__Stepfather__Custodial Relative __ Other

Biological Gender: Male/Female Preferred Gender if any: _________

Race: __White or Caucasian __Black or African American__ Asian __ Native American or American Indian __Alaskan Native or Native Hawaiian __ Other Pacific Islander __Other__ Decline to answer

Ethnicity: __Hispanic or Latino __ Not Hispanic or Latino__ Decline to answer

Home Address: ______________________ City: _____________ State: ___ Zip:________

Home Phone:_____________ Cell Phone:_______________ Email: ________________

Employer: _______________

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Work Address: ______________________ City: ________________ State: ___ Zip: ________

Work Phone: _______________

Social Security: ________________ Driver's License number: ______________

Preferred Language: ________________ Preferred method of Contact: __Home phone __Cell phone __ Email __Patient Portal

Responsible Party (Guarantor): ___ Yes ___ No

Parent/Legal Guardian

First Name: ____________________ Last Name: _________________ Middle Initial: _____

Preferred Name or Other Names Used if any: _________________

Date of Birth: ___________________

Relationship to Patient: __ Mother __ Father __Stepmother__Stepfather__Custodial Relative __ Other

Biological Gender: Male/Female Preferred Gender if any: _________________

Race: __White or Caucasian __Black or African American__ Asian __ Native American or American Indian __Alaskan Native or Native Hawaiian __ Other Pacific Islander __Other__ Decline to answer

Ethnicity: __Hispanic or Latino __ Not Hispanic or Latino__ Decline to answer

Home Address: ______________________ City: ____________ State: ___ Zip:________

Home Phone:_____________ Cell Phone:_______________ Email: ________________

Employer: _______________

Work Address: ______________________ City: ________________ State: ___ Zip:________

Work Phone:_______________

Social Security: ________________ Driver's License number: ______________

Preferred Language: ________________

Preferred method of Contact: __Home phone __Cell phone __Email __ Patient Portal

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Responsible Party (Guarantor): ___ Yes ___ No

Responsible Party/ Guarantor (*if not a Parent or Legal Guardian as above)*

First Name: ___________________ Last Name: ________________ Middle Initial: _____

Other Names Used if any: ________________

Date of Birth: __________________ Relationship to Patient: ________________

Home Address: _____________________ City: ____________State: ___ Zip: ________

Home Phone: ____________ Cell Phone: ______________ Email: _______________

Work Phone: ______________

Social Security: _______________ Driver's License number: _____________

Preferred Language: _______________

Preferred method of Contact: __Home phone __Cell phone __ Work phone __Email

Emergency Contact (*optional and may be omitted if Parents and Legal Guardians are emergency contacts)*

First Name: ___________________ Last Name: ________________ Middle Initial: _____

Other Names Used if any: ________________

Date of Birth: __________________ Relationship to Patient: ________________

Home Address: _____________________ City: _____________State: ___ Zip: ________

Home Phone: ____________ Cell Phone: ______________ Email: _______________

Work Phone: ______________

Social Security: _______________ Driver's License number: _____________

Preferred Language: _______________

Preferred method of Contact: __Home phone __Cell phone __ Work phone __Email

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Insurance Information

Primary Insurance Name: __________________

Member ID Number: ________________ Group Number: _______________

Rx Bin Number: _________________ Name of Policy Holder: ______________________________

Secondary Insurance Name: __________________

Member ID Number: ________________ Group Number: _______________

Rx Bin Number: _________________ Name of Policy Holder: ______________________________

Credit Card Information

__ Master Card __ Visa __ Amex

Name on Credit/Debit Card: ________________________

Credit/ Debit Card number: _________________________

Expiration Date: _______________ CVV: _______________ Zip:___________

Pharmacy Information

Name of Preferred Pharmacy: _______________________ Phone: _______________

Address: _____________ City: _________________ State: _____Zip: ___________

Name of Secondary Pharmacy: _______________________Phone: _______________

Address: _____________ City: _________________ State: ____Zip: ___________

Preferences

Any religious or cultural preferences for receiving medical care that we should be aware of? __ None

Or please explain: ____

Any preferred method of learning and receiving information regarding medical care? __ None

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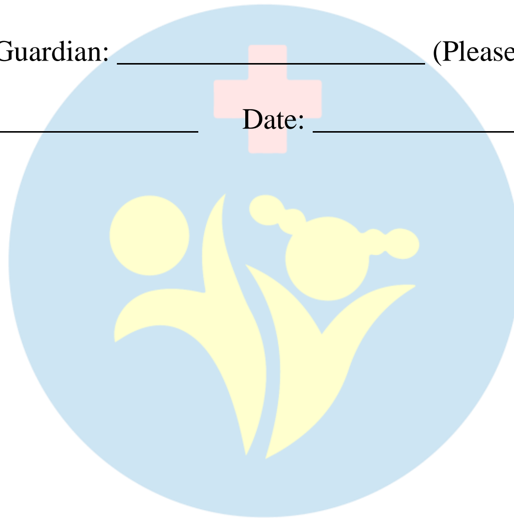
Or please explain: ____

I/We do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physician and staff of Happy Kids Pediatrics to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained herein are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, excluding only authorized services provided under a valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize Happy Kids Pediatrics to release information requested by insurance company and/or its representatives. I fully understand this agreement, and my consent will remain in effect until cancelled by me in writing.

Signature of Patient/Parent/Legal Guardian: _________________________

Name of Patient/Parent/Legal Guardian: ____________________ (Please Print)

Relationship to Patient: __________________ Date: ________________



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