

PATIENT REGISTRATION FORM

(Please print)

Today's date: / /

Patient's name (last, first middle)		Nickname	
<input type="checkbox"/> M <input type="checkbox"/> F			
Sex	Birth date	Preferred email	Preferred Phone number <input type="checkbox"/> Cell <input type="checkbox"/> Home

PARENT (OR LEGAL GUARDIAN) INFORMATION: Child lives with Mother Father Both Other

Mother's name (last, first middle)	Social security number	Date of birth
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Address	City	State	Zip
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Additional phone # <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Other	Additional phone # <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Other
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Father's name (last, first middle)	Social security number	Date of birth
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Address (if different from above)	City	State	Zip
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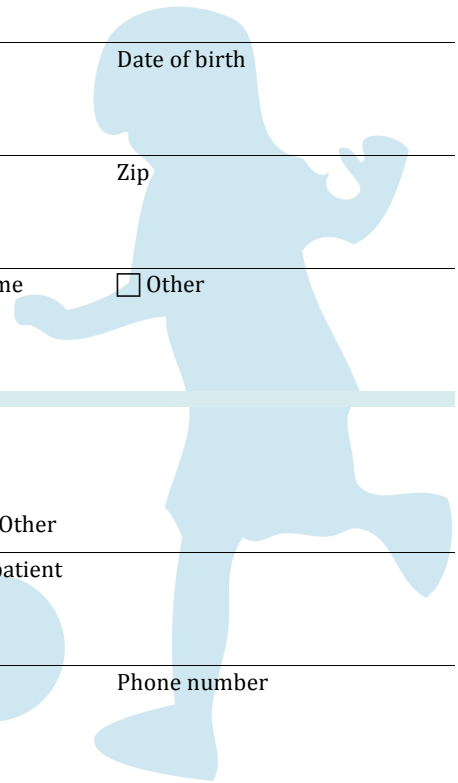
Additional phone # <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Other	Additional phone # <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Other
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BILLING ADDRESS (IF DIFFERENT FROM ABOVE)

Guardian Other

Attention to (name or industry)	Relationship to patient
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Address	City	State	Zip	Phone number
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INSURANCE INFORMATION

Is this patient covered by insurance? No, I will pay for visit Yes (please give insurance card to receptionist)

1. PRIMARY INSURANCE: HMSA QUEST-HMSA QUEST- ALOHACARE Other:

Subscriber ID #	Coverage code	Group	Effective date
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F	
Subscriber name	Patient's relationship to subscriber	Sex	Birth date

2. SECONDARY INSURANCE: HMSA QUEST-HMSA QUEST- ALOHACARE Other:

Subscriber ID #	Coverage code	Group	Effective date
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F	
Subscriber name	Patient's relationship to subscriber	Sex	Birth date

EMERGENCY CONTACT INFORMATION

Name of local friend or relative	Relationship to patient	Emergency contact #	Alternate contact #
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I certify that the above information is accurate and current to the best of my knowledge. By providing my cell phone number and/or email address, I consent to Reis Pediatrics contacting me regarding my child's medical care via cell phone, text or email.

