

PATIENT REGISTRATION FORM

TODAY'S DATE: / /

LIST ALL CHILDREN:

Patient's name (last, first middle) Nickname Sex (M of F) Date of Birth

Preferred email AND Preferred Cell phone number (for appointment reminders and contacting)

PARENT (OR LEGAL GUARDIAN) INFORMATION

Mother's name (last, first middle) Date of birth

Address City State Zip

Additional phone # Cell Home Work

Father's name (last, first middle) Date of birth

Address (if different from above) City State Zip

Additional phone # Cell Home Work

BILLING ADDRESS (IF DIFFERENT FROM ABOVE)

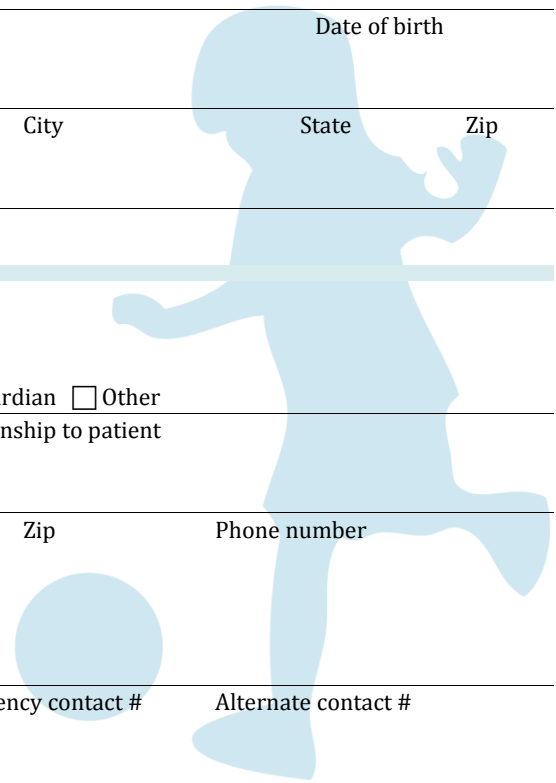
Guardian Other

Attention to (name or industry) Relationship to patient

Address City State Zip Phone number

EMERGENCY CONTACT INFORMATION

Name of local friend or relative Relationship to patient Emergency contact # Alternate contact #





Patient's name (Last, first middle) LIST ALL CHILDREN: _____

INSURANCE INFORMATION: Is this patient covered by insurance? No, I will pay for visit Yes (please give us a copy of card)

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

Subscriber ID # (Social security number if TRICARE)	Coverage code	Group	Effective date
	<input type="checkbox"/> Self <input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F	
Subscriber name	Patient's relationship to subscriber	Sex	Date of Birth

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

Subscriber ID # (Social security number if TRICARE)	Coverage code	Group	Effective date
	<input type="checkbox"/> Self <input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F	
Subscriber name	Patient's relationship to subscriber	Sex	Date of Birth

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.

Credit Card Payment Authorization: Visa Mastercard Prefer not to provide (Required for hospital newborns and visitors)

Name on Credit Card	Card Number	Exp. Date	Security Code

Billing Address

By signing below, you are agreeing to and understand the above financial agreement and that you understand, as the parent and/or guarantor of the minor child described above as being the patient, that you are responsible for any charges incurred and agree to pay them as required within 30 days of receiving your billing statement.

Print Name (parent or legal guardian)	Signature	Date

