EASTGLEN PEDIATRICS

PATIENT REGISTRATION FORM

Date: ______________

Please circle your doctor: Polster Mailloux Keller Black Bartsch Slaunwhite

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PATIENT INFORMATION

Name: ________________________________ Your Preferred Language: ____________________

Date of Birth: _____________ Sex: ☐ Male ☐ Female

Home Address: __________________________City: ________________State: _______Zip: _______

Sibling Names and Ages *(ex: Jack, 9)*: ____

PARENT/GUARDIAN INFORMATION

Primary Family Email: ______________________ Primary Family Phone: ( ) _____________________

Parent Name: ____________________________ DOB: ___________ S.S.# _____________

Cell Phone: ( ) __________________ Work Phone: ( ) ________________________

Home Address: _________________________City: ________________State:______ Zip:_______

(if different from Child)

Employer: _______________________________________

Parent Name: _______________________ DOB: _______________ S.S. #___________________

Cell Phone: ( ) ___________________ Work Phone: ( ) _______________________

Home Address: __________________City: ______________State:____________ __Zip: ________

(if different from child)

Employer: _______________________________________

ALTERNATE CONTACT

Name**:** (*relative/friend)* ____________________________Phone: ( ) _______________

Relationship to patient: _______________________________

FORM COMPLETED BY: ___________________________ ___________________________________

(*Print*) (*Signature)*

INSURANCE INFORMATION

Insurance Plan: ____

Effective Date: ________________ S.S.#______________________

Policy Holder Name: ____________________________ Policy Holder DOB: _______________ Sex: ☐ M ☐ F

Relationship to Patient: ___________________________

*****PLEASE NOTE:** The insurance policy holder is not automatically the Billing Guarantor. The parent/Guardian who is present for office visits is the Billing Guarantor ***

BILLING GUARANTOR

Name ______________________________ DOB: __________ Sex: ☐ M ☐ F

Address: ________________________________ City: ______________________ State: _____ Zip:__________

Primary Phone ( ) ________________________ S.S. # ____________________

ADDITIONAL INFORMATION

We are required to collect the following information for each Patient. Please complete this section before returning the form.

Preferred Method of contact: Phone: ___ Text: ___ Portal/Email: ____

Your Child's Race/Ethnicity: American Indian ☐ Asian ☐ Black/African American ☐

Caucasian ☐ Hispanic ☐ Multiracial ☐ Unknown ☐ Other ☐ ________________

Decline to answer ☐