KAPLAN BARRON PEDIATRIC GROUP

PATIENT REGISTRATION

Date: ____________

Child(ren)'s Name:	Name child likes to be called:	DOB:	Sex:	SSN:
1.				
2.				
3.				
4.				

Primary language spoken in the home: ____________

Ethnicity (check one) ☐ Hispanic / Latino ☐ Non-Hispanic ☐ Decline to answer

Race (check all that apply) ☐ American Indian ☐ Asian ☐ Black ☐ Hawaiian Native ☐ White

Patient's primary phone number: ____________ Email: ____________

Parent or Guardian Information:

Check one: ☐ Father ☐ Mother ☐ Stepfather ☐ Stepmother ☐ Guardian

Check one: ☐ Father ☐ Mother ☐ Stepfather ☐ Stepmother ☐ Guardian

Parent 1 Full Name: ____________

Address: ____________

City: ____________ State: ______ Zip: ____________

Home Phone: ____________

Cell Phone: ____________

Work Phone: ____________

Email: ____________

Employer: ____________

Address: ____________

City: ____________ State: ______ Zip: ____________

DOB: ____________ SSN: ____________

Lives with patient? (check one) ☐ Yes ☐ No

☐ Married ☐ Single ☐ Divorced

☐ Custodial Parent ☐ Guardianship ☐ Joint Custody

Parent 2 Full Name: ____________

Address: ____________

City: ____________ State: ______ Zip: ____________

Home Phone: ____________

Cell Phone: ____________

Work Phone: ____________

Email: ____________

Employer: ____________

Address: ____________

City: ____________ State: ______ Zip: ____________

DOB: ____________ SSN: ____________

Lives with patient? (check one) ☐ Yes ☐ No

☐ Married ☐ Single ☐ Divorced

☐ Custodial Parent ☐ Guardianship ☐ Joint Custody

If Parents Are Divorced or Separated, Please Complete the Following Section.

Who has Primary Custody? ______________________________

Are there any legal restrictions that would keep the non-custodial parent from consenting to medical treatment for the child, or from obtaining information about the child's medical treatment? ☐ YES ☐ NO

If yes, please explain, and provide our office a copy of any legal paperwork that supports this restriction. ______________________________

____

____

Insurance

Primary Insurance: ______________________________

ID #: ______________________________

Group #: ______________________________

Policy holder's last name: ______________________________

Policy holder's first name: ______________________ MI: ______

Policy holder's Birthdate: ______________________________

SSN: ______________________________

Secondary Insurance: ______________________________

ID #: ______________________________

Group #: ______________________________

Policy holder's last name: ______________________________

Policy holder's first name: ______________________ MI: ______

Policy holder's Birthdate: ______________________________

SSN: ______________________________

Privacy Constraints (check one)

☐ No restrictions: Okay to leave message / send mail. ☐ Restrictions: Person to person with patient / guardian only.

☐ Restrictions: ______________________________

Preferred Method of Contact for Medical Issues (check one)

☐ Home phone ☐ Work phone ☐ Cell phone ☐ Home email ☐ Text to cell

Preferred Method of Contact for Reminders (check one)

☐ Home phone ☐ Work phone ☐ Cell phone ☐ Home email ☐ Text to cell

Authorization to Pay Benefits to Physician:

I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to my *Provider, when he/she accepts assignment.*

Authorization to Release Medical Information:

I hereby authorize my Provider to release any information necessary for my course of treatment.

______________________________ ______________

Signature (Parent/Guarantor if minor) Date