Kaplan Barron Pediatric Group

Patient Registration

PATIENT INFORMATION

- Name _____Date of Birth: _____Sex / Gender: _____
- Name _____Date of Birth: _____Sex / Gender: _____
- Name _____Date of Birth: _____Sex / Gender: _____

- Primary Language Spoken at Home: _____

Ethnicity

○ Hispanic / Latino ○ Non-Hispanic ○ Decline to answer

Race

◉ American Indian ○ Asian ○ Black ○ Native Hawaiian / Pacific Islander ○ White

- Other: _____

PARENT / GUARDIAN INFORMATION

Relationship to Patient

- Parent/Guardian #1: ☐ Father ☐ Mother ☐ Stepfather ☐ Stepmother ☐ Guardian
- Parent/Guardian #2: ☐ Father ☐ Mother ☐ Stepfather ☐ Stepmother ☐ Guardian
- Parent/Guardian #1 Name: _____
- Parent/Guardian #2 Name: _____

- Address (Parent/Guardian #1): _____
- Address (Parent/Guardian #2): _____
- City: _____ State: _____ Zip: _____
- Parent/Guardian #1 Cell: _____
- Home Phone: _____
- Parent/Guardian #2 Cell: _____
- Parent/Guardian #1 Email: _____
- Parent/Guardian #2 Email: _____

Each parent/guardian must have a separate email for portal access.

- Lives with patient? ☐ Yes ☐ No
- ☐Married ☐Single ☐Divorced

Custody

- ☐Custodial Parent ☐Guardianship ☐Joint Custody

DIVORCE / SEPARATION INFORMATION (if applicable)

- Primary Custodian: _____
- Any legal restrictions on non-custodial parent? ☐ Yes ☐ No
    - If yes, explain: _____

INSURANCE INFORMATION

Primary Insurance

- Insurance Company: _____ID #: _____
- Group #: _____
- Policy Holder Name: _____ Policy Holder DOB: _____

Secondary Insurance

- Insurance Company: _____ ID #: _____
- Group #: _____
- Policy Holder Name: _____ Policy Holder DOB: _____

PRIVACY & COMMUNICATION PREFERENCES

Privacy Constraints

- ☐No restrictions (ok to leave message/send mail) OR ☐Restrictions (person-to-person only)

Preferred Contact Method (Medical Issues)

- ☐Home Phone ☐Cell Phone ☐Email ☐Text ☐

Preferred Contact Method (Reminders)

- ☐Home Phone ☐Cell Phone ☐Email ☐Text

AUTHORIZATIONS

Authorization to Pay Benefits to Physician:
I authorize the release of medical information necessary to process insurance claims and request payment of benefits to the provider.
Authorization to Release Medical Information:
I authorize my provider to release any information necessary for treatment.

- Signature (Parent/Guarantor): _____
- Date: _____