



**Patient Registration Form**  
(Please print and complete all sections)

<b>Patient's Information</b>			<b>Patient's Information</b>		
<b>Child #1:</b>	DOB:	M/F	<b>Child #2:</b>	DOB:	M/F
Child's Race (circle one): White, Black, Hispanic, Other _____			Child's Race (circle one): White, Black, Hispanic, Other _____		
Child's Primary Language (circle one): English, Spanish, Other _____			Child's Primary Language (circle one): English, Spanish, Other _____		
Child's Ethnicity (circle one): Non-Hispanic, Hispanic			Child's Ethnicity (circle one): Non-Hispanic, Hispanic		
<b>Child #3:</b>	DOB:	M/F	<b>Child #4:</b>	DOB:	M/F
Child's Race (circle one): White, Black, Hispanic, Other _____			Child's Race (circle one): White, Black, Hispanic, Other _____		
Child's Primary Language (circle one): English, Spanish, Other _____			Child's Primary Language (circle one): English, Spanish, Other _____		
Child's Ethnicity (circle one): Non-Hispanic, Hispanic			Child's Ethnicity (circle one): Non-Hispanic, Hispanic		
<b>Mother's Information</b>			<b>Father's Information</b>		
Name:	DOB:		Name:	DOB:	
Primary/Day Phone#:	WK/HM/CELL		Primary/Day Phone#:	WK/HM/CELL	
Secondary Phone#:	WK/HM/CELL		Secondary Phone#:	WK/HM/CELL	
Address	Apt#		Address	Apt#	
City	State	Zip	City	State	Zip
<b>Parent/Guardian Information:</b>					
Mother's Name: _____		Father's Name: _____			
Child(ren)'s Parents Are: Married   Divorced   Separated   Never Married Custodian of the Child(ren) Mother, Father, Both, Grandparent, Foster Parent, Other _____					
<b>Preferred Daytime Phone Number:</b> _____			<b>Preferred Email Address:</b> _____		
<b>Email Address Is Required for the Patient Portal. ABC Pediatrics may leave messages via home, cell or email.</b>					
<b>Authorize Text Notifications: Yes No   Authorize Voicemail: Yes No   Authorize Email Notifications: Yes No</b>					

**Primary Insurance Information**

Policy Holder's Name: \_\_\_\_\_

Policy Holder's DOB: \_\_\_\_\_ Primary Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**Secondary Insurance Information**

Policy Holder's Name: \_\_\_\_\_

Policy Holder's DOB: \_\_\_\_\_ Primary Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

*I acknowledge the above information provided is correct. I authorize treatment and payment for all medical services rendered by the medical providers and staff of ABC Pediatrics, PC.*

**Please sign and date: Parent/Guarantor/Responsible Party** \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Date \_\_\_\_\_