Patient Registration Form

(Please print and complete all sections)

Patient's Information	***Patient's Information***
Child #1: DOB: M/F	**Child #2:** 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
Child #3: DOB: M/F	**Child #4:** 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
Mother's/Guardian's Information	***Father's/Guardian's Information***
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

Child(ren)'s Parents Are: Married Divorced Separated Never Married

Custodian of the Child: Mother, Father, Foster Parent, Grandparent, Other _____

Daytime Phone Number: _____ Email Address: _____

Email Address Is Required for the Patient Portal. ABC Pediatrics may leave messages via home, cell or email.

Authorize Text Notifications: Yes No Authorize Voicemail: Yes No Authorize Email Notifications: Yes No

Medicaid ID Number: Please provide the Medicaid ID Number

Child #1: _____ Child # 2: _____

Amerigroup/Medicaid/Peachstate/CareSource (circle one)

Child #3: _____ Child # 4 _____

Amerigroup/Medicaid/Peachstate/CareSource (circle one)

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/Guardian/Responsible Party _____

Relationship to Patient _____ Date_____

November 2025