Patient Registration

PATIENT INFORMATION

Child 1: Last Name: ______________________ First Name: __________________ MI: _____

D.O.B.: _____/_____/_____ Sex: M/F Primary Language: __________________

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Pacific Islander / White/American Indian/Alaskan

Primary Care Provider (circle one): Karen Dettmer, MD Sophia Grant, MD Richard Tenczar, MD Michelle Henry, APRN

Patient cell phone (15+) _________________________

Child 2: Last Name: ______________________ First Name: __________________ MI: _____

D.O.B.: _____/_____/_____ Sex: M/F Primary Language: __________________

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race:* Asian / Black / Pacific Islander / White/American Indian/Alaskan

Primary Care Provider (circle one): Karen Dettmer, MD Sophia Grant, MD Richard Tenczar, MD Michelle Henry, APRN

Patient cell phone (15+) _________________________

Child 3: Last Name: ______________________ First Name: __________________ MI: _____

D.O.B.: _____/_____/_____ Sex: M/F Primary Language: __________________

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race:* Asian / Black / Pacific Islander / White/American Indian/Alaskan

Primary Care Provider (circle one): Karen Dettmer, MD Sophia Grant, MD Richard Tenczar, MD Michelle Henry, APRN

Patient cell phone (15+) _________________________

Mailing Address:____

Home Phone: (______) ________ - ___________

INSURANCE

Primary Policy: ☐ Check if HUSKY/Medicaid and skip to contacts section

Policy Holder's Name: ____

Policy Holder's Birth Date: ___________________ Policy Holder's Sex: Male / Female

Insurance Carrier: ____

ID# ______________________________________ Group # __________________________

Secondary Policy: ☐ Check if HUSKY/Medicaid and skip to contacts section

Policy Holder's Name: ____

Policy Holder's Birth Date: ___________________ Policy Holder's Sex: Male / Female

Insurance Carrier: ____

ID# ______________________________________ Group # __________________________

CONTACTS
All routine contact will be made to parent/guardian #1 unless otherwise requested below.

Parent/guardian 1: Name: ________________________________ Date of Birth: ____ / ____ / ____

Relation to Patient: ______________________ Lives with patient? Yes / No

Home Phone: (____) ______ - ___________ Cell Phone: (____) ______ - ___________

Work Phone: (____) ______ - ____________ Home Email: ________________________________

Employer: __________________________________ Occupation: _________________________________

Address (if different from patient)____

How would you ideally prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Work Phone / Cell Phone / Home Email

Appointment Reminders: Home Phone / Cell Phone / Home Email

Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone / Home Email

Billing Statements: Home Address / Home e-mail

General Practice Notices: Home Address / Home Phone / Cell Phone / Home Email

Patient Portal Notifications: Cell Phone / Home Email

Parent/guardian 2: Name: ________________________________ Date of Birth: ____ / ____ / ____

Relation to Patient: ______________________ Lives with patient? Yes / No

Home Phone: (____) ______ - ___________ Cell Phone: (____) ______ - ___________

Work Phone: (____) ______ - ___________ Home Email: ________________________________

Employer: __________________________________ Occupation: _________________________________

Address (if different from patient)____

If this contact will need to be notified in addition to parent/guardian #1 for routine care, please circle the preferred contact method: *Home Phone / Cell phone / Work phone / Email*

Additional Contact Questions:

Who should receive billing statements? ____

May all contacts have access to the patient's records electronically? Yes / No / __________

If parents are divorced or separated please fill out this section:
Who has custody? ____
Are there any legal restrictions that would restrict 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 a copy of any legal paperwork that supports this restriction.

____

Emergency Contacts, <u>other than parents</u>: Name & Relationship

1: ____ *Phone*: (______) ________ - ___________

2: ____ *Phone*: (______) ________ - ___________