

**PEDIATRIC
PATIENT REGISTRATION**

Date: _____

Patient	Last Name _____ First Name _____ Initial _____ Date of Birth _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male Address _____ City _____ State _____ Zip _____ Phone – Home _____ Preferred Message/Contact Phone _____ Race (please circle) Asian Black Hispanic Native American Other Refused Unknown White Primary Language _____ Has patient been seen at a Saint Alphonsus Medical Group or Express Care Clinic in the past 3 years? <input type="checkbox"/> Yes <input type="checkbox"/> No Who was the patient's last provider? _____ Preferred Pharmacy _____ Major Crossroads _____	
Health Insurance	Primary Insurance _____ Policy Holder Name _____ Date of Birth _____ Employer _____ Relationship to Patient _____ Employer Address _____ City _____ State _____ Zip _____ Secondary Insurance _____ Policy Holder Name _____ Date of Birth _____ Employer _____ Relationship to Patient _____ Employer Address _____ City _____ State _____ Zip _____ <i>Office Staff: if unable to scan card, make copy of card and attach to this form. If card unavailable, but patient has group & subscriber number, please write numbers on this form.</i>	
People assisting with paperwork:		
Interpreter's name _____	Interpreter's Signature and/or ID # _____	Date and Time _____
Office Staff name _____	Office Staff Signature _____	Date and Time _____

Place patient sticker here or handwrite

Name _____

DOB: _____

Guardian/ 1st Parent	Last Name _____ First Name _____ Initial _____ Social Security Number _____ Date of Birth _____ Sex _____ Address (if different from patient) _____ City _____ State _____ Zip _____ Phone – Home _____ Work _____ Cell _____ Marital Status _____ Email _____ Employer _____ Relationship to Patient _____ Employer Address _____ City _____ State _____ Zip _____
Additional Contact (not living with you)	Last Name _____ First Name _____ Phone Number _____ Address _____ City _____ State _____ Zip _____ Relationship to Patient _____
2nd Parent	Last Name _____ First Name _____ Initial _____ Social Security Number _____ Date of Birth _____ Sex _____ Address (if different from patient) _____ City _____ State _____ Zip _____ Phone: Home _____ Work _____ Cell _____ Preferred Message/Contact Phone _____ Marital Status _____ Employer _____ Relationship to Patient _____ Employer Address _____ City _____ State _____ Zip _____

Place patient sticker here or handwrite

Name _____

DOB: _____