Pediatric Associates of Montgomery County, PA
Patient Registration

Child #1: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _____ *Primary Language:* _____

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White

Child #2: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _____ *Primary Language:* _____

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White

Child #3: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _____ *Primary Language:* _____

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White

Mailing Address:

_____

(Street or PO Box) *(City)* *(State & Zip)*

Home Phone: (_____) _____ - _____

Who lives at this household? _____

Insurance:

Primary Policy: *Policy Holder's Name*: _____

Policy Holder's Birth Date: _____ *Policy Holder's Sex:* Male / Female

Insurance Carrier: _____

ID# _____ *Group #* _____

Secondary Policy: *Policy Holder's Name*: _____

Policy Holder's Birth Date: _____ *Policy Holder's SSN:* _____

Insurance Carrier: _____

ID# _____ *Group #* _____

Parent/Guardian #1: *Name*: _____ *Relation to Patient*: _____

Lives with patient? Yes / No *Date of Birth:* _____ / _____ / _____ *Social Security #:* _____ - _____ - _____

Cell Phone: (_____) _____ - _____ *Work Phone*: (_____) _____ - _____

Home Email: _____ *Work Email*: _____

Employer: _____ *Occupation*: _____

How do you prefer to be contacted regarding: (circle one for each category)

Medical Issues:	Home Phone / Cell Phone
Appointment Reminders/Recall notices:	Home Phone / Cell Phone / Home Email / Work Email
Billing Statements:	Home Address / Home e-mail / Work Email

Best Phone Number to be reached on: _____

Parent/Guardian #2: *Name*: _____ *Relation to Patient*: _____

Lives with patient? Yes / No *Date of Birth:* _____ / _____ / _____ *Social Security #:* _____ - _____ - _____

Cell Phone: (_____) _____ - _____ *Work Phone*: (_____) _____ - _____

Home Email: _____ *Work Email*: _____

Employer: _____ *Occupation*: _____

If Contact 2 is not a parent/guardian, does he/she have authority to bring in the patient without a parent as well as make any medical decisions on the parent's behalf? Yes / No / N/A

By signing below I authorize the above named person to make medical decisions on my behalf:

_____ _____

Signature **Date**

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: (Other than parents).

Name: _____ *Relationship:*_____ *Phone*: (_____) _____ - _____

Name: _____ *Relationship:*_____ *Phone*: (_____) _____ - _____