MiKiDS PEDIATRICS

NEW PATIENT / FAMILY REGISTRATION FORM

Child

#1 Last_____ First_____ MI____ Nickname _____DOB__/___/_____

#2 Last_____ First_____ MI____ Nickname _____DOB__/___/_____

#3 Last_____ First_____ MI____ Nickname _____DOB__/___/_____

#4 Last_____ First_____ MI____ Nickname _____DOB__/___/_____

#5 Last_____ First_____ MI____ Nickname _____DOB__/___/_____

Main Mailing Address:

Address_____ City_____ State_____ Zip_____

Main contact phone(_____)_____ Person to whom phone belongs_____

Contact 1 ❑ parent ❑ guardian

Name_____ Relationship to patient_____ Lives with patient ❑ yes ❑ no

Address if different from children_____

DOB__/___/_____ SS#_____ Cell phone(_____)_____ email_____

Employer_____Occupation_____Work phone(_____)_____

Contact 2 ❑ parent ❑ guardian

Name_____ Relationship to patient_____ Lives with patient ❑ yes ❑ no

Address if different from children_____

DOB__/___/_____ SS#_____ Cell phone(_____)_____ email_____

Employer_____Occupation_____Work phone(_____)_____

Additional contact information:

If parents are divorced, separated, or not living/ parenting together, please answer the following:

What is the custody arrangement?_____

Are there legal restrictions on the non-custodial parent when it comes to medical decision making? Please supply legal paperwork verifying this.

Are there other family members who may be involved in decision making? _____

Insurance Information:

Primary policy:

Insurance carrier:_____

Policy holders name_____

Policy holder's DOB__/___/_____

ID #_____Group #_____

Secondary policy:

Insurance carrier:_____

Policy holders name_____

Policy holder's DOB__/___/_____

ID #_____Group #_____

Emergency Contacts:

Name_____ Relationship to patient_____ Phone number (_____)_____

Name_____ Relationship to patient_____ Phone number (_____)_____