

## Patient Registration Form

Today's date:	Previous PCP (if any):								
PATIENT INFORMATION									
Patient's Full Name (First,	:		Date of B	irth:		Social Security #:			
Ethnicity? Race: ☐ Hispanic ☐ Non-Hispanic ☐ African-Amer ☐ Unknown ☐ Decline ☐ American Ind ☐ Asian			ican						
Nickname:	Age:	Sex (on birth certificate): Gender Identity/Pronouns  ☐ Male ☐ Female				y/Pronouns:			
Street address:						Hom	e phone #:		
City:			State: Zip			Code:			
Grade:	ade: School:					Prefe	erred Language:		
How did you find us? Pleas Insurance Plan Family: Other:	☐ Google ☐ Friend:				Referred by: Close to home				
Siblings (names and birthdates): #2:									
EMERGENCY CONTACTS (OTHER THAN PARENTS)									
#1: Name (First, Last):				Mobile Number:					
Address, City/State and ZII	Но			Home Phone Number:					
#2: Name (First, Last):	R	Relationship to patient:			Mobile Number:				
Address, City/State and ZI		Hon			Home Ph	lome Phone Number:			
PHARMACY INFORMATION									
Pharmacy Name:	Add	lress:			Telepho	one Num	ber:		

INSURANCE INFORMATION										
(Please give your insurance card to the receptionist.)										
Is this patient covered	by insurance	? 🗖	Yes	□ N	o (Self-Pa	ay)				
Responsible Party:	Birth date:			Address:			Нс	Home phone:		
Occupation:	Employer:		Employer addr				Em	Employer phone:		
Name of Primary Insurance Company:										
Subscriber's name:			Birt	h date:		Group #:		Policy #:		
Patient's relationship to subscriber:			Self	☐ Ch	☐ Other					
Name of secondary insurance Subscribe (if applicable):			ber's	name:		Group #:	Group #:		Policy #:	
Patient's relationship t	o subscriber:		Self	☐ Ch	ild	☐ Other				
FAMILY/CONTACT INFORMATION										
Patient resides primarily with:										
☐ Both Parents ☐ Parent #1 (list information below) ☐ Parent #2 (list information below)										
Legal Guardian: Other:										
Parents are:   Married Divorced Separated Other:										
Parent/Legal Guardian #1's Name and Birth Date:					Relationship to patient:					
What does your child call you? (e.g. Mom, Papa, etc)								Papa, etc)		
Home phone number: Mobile number:			r:	E-mail:						
Occupation: Employe				Employe	er & Work Number:					
Lives with patient?										
The best way to reach	me is:	☐ Home nur	nber		obile nu	mber 🔲 🔾	Nork r	number	☐ E-mail	
Puddle Dock Pediatrics may leave messages or lab results via:							☐ E-mail			
Parent/Legal Guardian #2's Name and Birth Date: Relationship to patient:										
				What does your child call you? (e.g. Mom, Papa, etc)						
Home phone number:		Mobile nu	mbei	r:		E-mail:				

Occupation:	Employer & Work Number:							
Lives with patient?    Yes    No	If you do not live with the patient, please provide the address (please disregard if same as Parent/Legal Guardian #1).							
The best way to reach me is:	☐ Mobile number	☐ Work	number	☐ E-mail				
Puddle Dock Pediatrics may leave messages or lab res	ults via: 🔲 Home #	☐ Mobile #	☐ Work #	☐ E-mail				
ADDITIONAL CONTACT QUESTIONS								
Who should receive billing statements?								
May all contacts have access to the patient's records?								
If parents are divorced, separated, or unmarried, please fill out this section:								
Who has custody?								
Are there are 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 a	ny legal paperwork that	supports this re	striction.					
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Puddle Dock Pediatrics, PLLC or insurance company to release any information required to process my claims.								
I give permission for Puddle Dock Pediatrics to contact me via e-mail and/or text message.								
Patient/Guardian signature	Date							