Pediatric Care North

PATIENT REGISTRATION FORM

Last Name	Middle Name	First Name

Birth Date:________________ Male____________________ Female __________________ Nickname___________________

Address:____________________________ Primary Phone:( )______________________Secondary Phone:( )__________________
Street____
City State Zip Code

Status of Parents: Married ☐ Seperated ☐ Divorced ☐ Widowed ☐ Unmarried ☐

Parent(s) or Guardian(s) Information
____Primary Phone( )________________________________
Last Name First Name
CHECK ONE: RELATIONSHIP TO PATIENT(S): Mother ☐ Step-Mother ☐ Grandparent ☐ Foster Parent ☐ Other _______________
Email Address:______________________________________Cell Phone: ( )____
Address:____
Place of Employment:_______________________SS#_________________DOB:________Work Phone: ( )_____________________

Parent(s) or Guardian(s) Information
____Primary Phone( )________________________________
Last Name First Name
CHECK ONE: RELATIONSHIP TO PATIENT(S): Father ☐ Step-Father ☐ Grandparent ☐ Foster Parent ☐ Other ________________
Email Address:______________________________________Cell Phone: ( )____
Address:____
Place of Employment:_______________________SS#_________________DOB:________Work Phone: ( )_____________________

WITH WHOM DOES THE CHILD RESIDE? Father ☐ Mother ☐ Legal Guardian ☐ Step Parent ☐ Foster Parent ☐ Other__________
If child/children are living with step parent or other relative, please complete the following:
Name:_________________________________ DOB:________ Employer:_____________________ Phone#( )__________________

Health Insurance:
1) Company Name:__________________________________
Policy ID#:____
Subscriber's Name:__________________________________
Group#:____
CHECK ONE: RELATIONSHIP OF SUBSCRIBER TO PATIENT
MOTHER ☐ FATHER ☐ GRANDPARENT ☐ OTHER ☐

Health Insurance:
2) Company Name:__________________________________
Policy ID#:____
Subscriber's Name:__________________________________
Group#:____
CHECK ONE: RELATIONSHIP OF SUBSCRIBER TO PATIENT
MOTHER ☐ FATHER ☐ GRANDPARENT ☐ OTHER ☐

I authorize Pediatric Care North to release any and all medical records, pertaining to my child's health, to my insurance company for any requested additional information.

Parent's Signature____ Date____

CONSENT OF TREATMENT

The physicians of Pediatrics Care North have my permission to provide my child/children with any necessary treatment.
The following persons have my permission to seek medical attention for my child/children in my absence.

1)____ 3)____
2)____ 4)____

Parent's Signature____ Date___________________________________