PEDIATRIC PATIENT REGISTRATION

Date: ___________________________

PLEASE PRESENT YOUR DRIVER'S LICENSE AND INSURANCE CARDS TO RECEPTION DESK.

PATIENT GENERAL INFORMATION:

Legal Last Name: _____________________________________

Legal First Name: ______________________________ MI ___

First Name Used: ______________

Pronouns Preferred: ☐ he/him/his ☐ she/her/hers ☐ they/them/their

Assigned Sex at Birth: ☐ M ☐ F ☐ Choose not to disclose

Date of Birth: __________ S.S. # ______________________

Address: ____

____

____

City ST Zip Code

____

PARENT INFORMATION:

Last Name: ____

First Name: ___________________________________ MI ___

Home Phone: _______________ Cell Phone: _______________

Work Phone: _________________________________

May we call you at work? ☐ Yes ☐ No

Email: ____

Preferred Contact # ☐ Home ☐ Work ☐ Cell ☐ Email

Language:___________________ Race: ________________

Ethnicity: _____________________ ☐ Decline to Answer

____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner

Pediatrician:____

How did you hear about us? ☐ Advertising ☐ Physician

Referring Physician's Name: ____________________________

☐ Word of Mouth ☐ Patient in the Practice ☐ Hospital

☐ Insurance Company ☐ Other: ______________________
Please specify

EMERGENCY CONTACT INFORMATION:

Contact Name: ___________________________________

Contact Relation: _________________________________

Contact Phone: ___________________________________

Contact Cell Phone: _______________________________

____

PARENT'S EMPLOYER INFORMATION:

Name: ____

Address: ____

____

City ST Zip Code

Phone: ____

Occupation: ______________________________________

____

GUARANTOR INFORMATION:

Patient's Relationship to Guarantor: ________________

GUARANTOR (*name to whom statements are sent*)

Last Name: ____

First Name: _______________________________ MI ___

Guarantor Date of Birth: __________________________

Mailing Address ☐ Same as patient's?

Address: ____

____

____

City ST Zip Code

Optional Guarantor Information:

S.S.#:______________________ Phone:_______________

Email: ____

CONTACT INFORMATION FOR APPOINTMENT REMINDERS:

Phone #: ____

*Valley Medical Group is the "trading as" name for Valley Physician Services, PC, Valley Medical Services, PC, and Valley Physician Services, NY, PC

INSURANCE INFORMATION: Policy Holder's Name: ____
Last Name First Name MI

Sex: ☐ M ☐ F Relationship to Patient: ☐ Mother ☐ Father ☐ Other: ______________________

Date of Birth: _________________ S.S. # _________________________

Address: ____

____
City ST Zip Code

Home Phone: ____________________________ Cell Phone: ________________________________

Work Phone: ____________________________ Email: ____

Policy Holder's Employer: ____

Employer's Address: ____

____
City ST Zip Code

Primary Insurance Company: ____

Policy Holder's ID: __________________________ Group #: ____

Insurance Company Address: ____

____
City ST Zip Code

Secondary Insurance Company: ____

Policy Holder's ID: __________________________ Group #: ____

Insurance Company Address: ____

____
City ST Zip Code

PHARMACY INFORMATION:

Local Pharmacy Name: ____ Phone: ____________________

Address: ____

Mail Order Pharmacy Name: ____ Phone: ___________________

Address: ____

PREFERRED LABORATORY: Name: ___________________________________ Phone: __________________

Address: ____ Fax: ___________________

Parent/Guardian: ____

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