PEDIATRIC PATIENT REGISTRATION

Thank you for choosing the Kireker Center for Child Development **Date: ________________________**

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

PATIENT GENERAL INFORMATION:

Last Name: ______________________________________

First Name: _________________________________ MI ___

Sex: ☐ M ☐ F 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: ____

☐ 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: ______________________

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