Pinecone Pediatrics

Patient Registration

(PLEASE PRINT CLEARLY)

Patient's Legal Name: _____
Last First Middle

Address: _____
Street Apt. #

_____
City State Zip

Date of Birth (Mo./Day/Year): _____ Age: _____ Sex (circle): M F

Home #: (_____)_____ Cell #: (_____)_____ Other #: (____)_____

Email: _____ Referred by: _____

Parent/Legal Guardian: _____ Parent/Legal Guardian: _____

Address (if different): _____ Address (if different): _____

_____ _____

Birthdate: _____ Birthdate: _____

Employer: _____ SS#:_____ Employer: _____ SS#:_____

Preferred Contact #: _____ Preferred Contact #: _____

Parent's Marital Status (circle): Married Widowed Divorced Single Legally Separated Other

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Insurance Information

Primary Ins. Name: _____ Secondary Ins. Name: _____

Policy Holder: _____ DOB: _____ Policy Holder: _____ DOB: _____

Relationship to Patient: _____ Relationship to Patient: _____

Policy ID#: _____ Policy ID#: _____

Group #: _____ Group #: _____

I agree that the above is true and correct to the best of my knowledge. I understand that the office policy is that the parent who requests treatment for the child is responsible for the costs associated with services rendered.

Print Name (Parent): _____ Relationship to Above Patient: _____

Signature of Parent: _____ Date: _____