North Willow Grove Pediatrics
New Patient Registration

Patient: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _____ *Primary Language:* _____

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White

Mailing Address:

(Street or PO Box) *(City)* *(State & Zip)*

Primary Phone: (_____) _____ - _____ **Phone number for reminder calls.**

Contact 1: *Name*: _____ Mother or Father/ Genetic or Adoptive

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____ *Social Security #:* ____ - ___ - _____

Work Phone: (____) _____ - _____ *Mobile Phone*: (____) _____ - _____

Occupation: _____

How would you ideally prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Mobile Phone / Email

Recall Notices: Home Address / Home Phone / Mobile Phone / Email

Contact 2: *Name*: _____ Mother or Father/ Genetic or Adoptive

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____ *Social Security #:* ____ - ___ - _____

Work Phone: (____) _____ - _____ *Mobile Phone*: (____) _____ - _____

Occupation:_____

How would you ideally prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Mobile Phone / Email

Recall Notices: Home Address / Home Phone / Mobile Phone / Email

Insurance:

Primary Policy: *Policy Holder's Name*: _____

Policy Holder's Birth Date: _____ Policy Holder's Sex: Male / Female

Secondary Policy: *Policy Holder's Name*: _____

Policy Holder's Birth Date: _____ *Policy Holder's SSN:* _____

PLEASE PROVIDE CARD FOR VERIFICATION AT EVERY VISIT

SEE OTHER SIDE

Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records electronically? Yes / No / _____

If parents are divorced or separated please fill out this section:
Who has custody? _____
Are there 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 any legal paperwork that supports this restriction.

Step-parent: *Name*: _____

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____ *Social Security #:* ____ - ___ - _____

Work Phone: (____) _____ - _____ *Cell Phone*: (____) _____ - _____

Occupation:_____

Step-parent: *Name*: _____

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____ *Social Security #:* ____ - ___ - _____

Work Phone: (____) _____ - _____ *Cell Phone*: (____) _____ - _____

Occupation:_____

Staff note: Any legal documentation must be given to the office manager for system updates.