All About Children Pediatrics

Patient Registration/Information Form

Please complete the entire form with current accurate information

*List **ALL** children under the age of 18. Patients 18 and older need to fill out their own form.*

Child (patient) 1

Legal Last Name:	**Legal First Name:**	**Middle Initial:**
Nickname (if applicable):	**Date of Birth:**	**Gender:** ☐ Male ☐ Female
Race (list all that apply):	**Primary Language:**	**Country Born In:**

Child (patient) 2

Legal Last Name:	**Legal First Name:**	**Middle Initial:**
Nickname (if applicable):	**Date of Birth:**	**Gender:** ☐ Male ☐ Female
Race (list all that apply):	**Primary Language:**	**Country Born In:**

Child (patient) 3

Legal Last Name:	**Legal First Name:**	**Middle Initial:**
Nickname (if applicable):	**Date of Birth:**	**Gender:** ☐ Male ☐ Female
Race (list all that apply):	**Primary Language:**	**Country Born In:**

Child's/Children's Primary Home Address (*circle who they live with*) **If you circle one of the below, please write their address on the back of this form*

Both Parents ☐	*Mom* ☐	*Dad* ☐	*Grandparent* ☐	*Sibling* ☐	*Legal Guardian* ☐

Parent Information

Mother's Full Legal Name:	**Father's Full Legal Name:**
Address:	**Address:**
City: **State:** **Zip:**	**City:** **State:** **Zip:**
Birthdate: **SS #**	**Birthdate:** **SS #**
Home Phone: (612) **Cell Phone:** (612)	**Home Phone:** (612) **Cell Phone:** (612)
Employer:	**Employer:**
Email Address:	**New Patient Portal:** Sign us up for Portal Access (email address is required): **Yes** ☐ **No** ☐

Parent's Marital Status (circle)

Married ☐	*Widowed* ☐	*Divorced* ☐	*Not Married* ☐	*Legally Separated* ☐	*Partner* ☐	*Other(state)* ☐

Billing Information (Please be prepared to present your insurance card – Co-pays are due at the time of service)

Name of Person Responsible For Account Bills:		
Primary Insurance Name:	**Policy Holder:**	**Effective Date:**
Secondary Insurance Name:	**Policy Holder:**	**Effective Date:**

Emergency Contact – *Other than Parent*

Contact:	**Relationship to child/children:**
Home Phone:	**Cell Phone:**

Parent/Legal Guardian Signature:_____ **Date:**_____

Printed Name of Signer:_____ **Relationship to Child:**_____

All About Children Pediatrics

Patient Registration/Information Form (page 2)

*** Please list your additional Children below ***

Child (patient) **4**

Legal Last Name:	**Legal First Name:**	**Middle Initial:**
Nickname (if applicable):	**Date of Birth:**	**Gender:** ☐ Male ☐ Female
Race (list all that apply):	**Primary Language:**	**Country Born In:**

Child (patient) **5**

Legal Last Name:	**Legal First Name:**	**Middle Initial:**
Nickname (if applicable):	**Date of Birth:**	**Gender:** ☐ Male ☐ Female
Race (list all that apply):	**Primary Language:**	**Country Born In:**

Child (patient) **6**

Legal Last Name:	**Legal First Name:**	**Middle Initial:**
Nickname (if applicable):	**Date of Birth:**	**Gender:** ☐ Male ☐ Female
Race (list all that apply):	**Primary Language:**	**Country Born In:**

Child (patient) **7**

Legal Last Name:	**Legal First Name:**	**Middle Initial:**
Nickname (if applicable):	**Date of Birth:**	**Gender:** ☐ Male ☐ Female
Race (list all that apply):	**Primary Language:**	**Country Born In:**

Child (patient) **8**

Legal Last Name:	**Legal First Name:**	**Middle Initial:**
Nickname (if applicable):	**Date of Birth:**	**Gender:** ☐ Male ☐ Female
Race (list all that apply):	**Primary Language:**	**Country Born In:**

**** If you specified that the patient(s) live with a Grandparent, Sibling, or Legal Guardian, please write their address below:***

Relative/Guardian's Legal Name:	**Relative/Guardian's Legal Name:**
Address:	**Address (if different):**
City: **State:** **Zip:**	**City:** **State:** **Zip:**
Home Phone: **Cell Phone:** ( ) ( )	**Home Phone (if different):** **Cell Phone:** ( ) ( )