

Country Kids Pediatrics  
Patient Registration

**Child 1:** Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

D.O.B.: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: \_\_\_\_\_ Primary Language: \_\_\_\_\_

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

**Child 2:** Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

D.O.B.: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: \_\_\_\_\_ Primary Language: \_\_\_\_\_

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

**Child 3:** 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)

Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Who lives at this household? \_\_\_\_\_

**Insurance:**

**Primary Policy:** Policy Holder's Name: \_\_\_\_\_

Policy Holder's Birth Date: \_\_\_\_\_ Policy Holder's Sex: Male / Female

Insurance Carrier: \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

**Secondary Policy:** Policy Holder's Name: \_\_\_\_\_

Policy Holder's Birth Date: \_\_\_\_\_ Policy Holder's SSN: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

**Contact 1:** Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Lives with patient? Yes / No Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Work Phone: ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Home Email: \_\_\_\_\_ Work Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

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

*Medical Issues:* Home Phone / Work Phone / Cell Phone / Home Email

*Appointment Reminders:* Home Phone / Cell Phone / Home Email / Work Email

*Recall Notices:* Home Address / Home Phone / Work Phone / Cell Phone / Home Email

*Billing Statements:* Home Address / Home e-mail / Work Email

*General Practice Notices:* Home Address / Home Phone / Cell Phone / Home Email

*Patient Portal Notifications:* Cell Phone / Home Email / Work Email

**Contact 2:** Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Lives with patient? Yes / No Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Work Phone: ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Home Email: \_\_\_\_\_ Work Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

If this contact will need to be notified in addition to Contact 1 for Medical Issues, Appointment Reminders, Recall Notices, Billing Statements, General Practice Notices and Patient Portal Notifications list their preferences here: \_\_\_\_\_

**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.

**Emergency Contacts, other than parents:** Name & Relationship

1: \_\_\_\_\_ Phone: ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

2: \_\_\_\_\_ Phone: ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_