Right from the Start Pediatrics – Patient Registration Sheet

Patient information

First Name ____________________ Middle Name _____________ Last Name _____________________
Sex M F Date of Birth _____________________ Social Security # __________________
Address ____
City ___________________________ State ______ Zip Code ________________________
Home phone _________________Work phone _________________ Cell phone ________________
E-mail address ____

These items assist in meeting electronic medical record compliance guidelines.

Language English Other (please specify) _______________________________________
Race White Black (African American) Asian
American Indian or Alaska native Native Hawaiian / Pacific Islander
Other (please specify) ____
Ethnicity Not Hispanic or Latino Hispanic or Latino Unknown

Insurance Information - *PLEASE SUPPLY INFORMATION FOR BOTH PARENTS AND BE PREPARED TO SHOW INSURANCE CARD AT ALL VISITS AND PAY CO-PAYMENT(S).*

Primary Insurance Card Holder / PARENT #1

First Name ____________________ Middle Name ____________________ Last Name ______________
Sex M F Date of Birth _____________________ Social Security # __________________
Address ____
City ___________________________ State ______ Zip Code _________________________
E-mail address ____

Employer ___________________________ Address ____
Phone ______________________________ Allowed to leave clinically related messages? Y N

Preferred Method of Contact HOME WORK CELL E-MAIL
Insurance Name ____________________________________ Phone _____________________________
ID # ____ Group # ____________________________

Secondary Insurance Card Holder / PARENT #2

First Name ____________________ Middle Name ____________________ Last Name ______________
Sex M F Date of Birth _____________________ Social Security # __________________
Address ____
City ___________________________ State ______ Zip Code _________________________
E-mail address ____

Employer ___________________________ Address ____
Phone ______________________________ Allowed to leave clinically related messages? Y N

Preferred Method of Contact HOME WORK CELL E-MAIL
Insurance Name ____________________________________ Phone _____________________________
ID # ____ Group # ____________________________

NOTE: IF MEDICAID PATIENT - PCP NEEDS TO BE DR. MORRA PRIOR TO BEING SEEN

Parent / Guardian Signature ____Date __________________