Suburban
Pediatric Associates

2018

Patient Registration Form

☐ New Patient ☐ Update Date: ___/___/_____

Children's Names	Gender	Birthdate	Race*	Ethnicity
				☐ Hispanic/Latino ☐ Not Hispanic/Latino
				☐ Hispanic/Latino ☐ Not Hispanic/Latino
				☐ Hispanic/Latino ☐ Not Hispanic/Latino
				☐ Hispanic/Latino ☐ Not Hispanic/Latino
				☐ Hispanic/Latino ☐ Not Hispanic/Latino

***Race** = White American, Native American, Alaska Native, Asian American, Black or African American, Hawaiian, Other Pacific Islander

Religion______________________ Do you need help understanding any health information given in office? _______

Preferred Language ________________ Do you need an interpreter? ☐ Yes ☐ No

Preferred Pharmacy ____________________ Who is your Primary Care Provider at SPA? __________________

Which location do you visit most frequently? _________________

If Patient is over 18 years of age, we need his/her name and contact phone number.

Name: _______________________________________ Phone Number: _________________________________

Family Information

Parent's Name: ______________________________ Birthdate: ____________ Responsible Party? ☐ Yes ☐ No

Home Address: _________________________________ City: ___________________ State ______ Zip ___________

Telephone: Home: _______________________ Work: ________________________ Cell: _______________________

Employer: ____ Position: ____________________________________

Email address ____

Parent's Name: ______________________________ Birthdate: ____________ Responsible Party? ☐ Yes ☐ No

Home Address: _________________________________ City: ___________________ State ______ Zip ___________

Telephone: Home: _______________________ Work: ________________________ Cell: _______________________

Employer: ____ Position: ____________________________________

Email address ____

*Is it okay to send you information on health-related topics via email? ☐ Yes ☐ No

If someone other than the parent is the responsible party, please fill out the following information:

Parent's Name: ______________________________ Birthdate: ____________ Responsible Party? ☐ Yes ☐ No

Home Address: _________________________________ City: ___________________ State ______ Zip ___________

Telephone: Home: _______________________ Work: ________________________ Cell: _______________________

Employer: ____ Position: ____________________________________

Email address ____

*****Please Complete All Pages of This Form*****

Primary Insurance

Insurance Company Name: ______________________ Effective Date: ______________

Policyholder Name: ______________________ Birthdate: ______________

Social Security Number: ______________ Relationship to Patient: ______________

Employer Name: ______________________ Group Number ______________

Policy/ID Number: ______________ Copay Amount ________ or ________% of Visit

Secondary Insurance

Insurance Company Name: ______________________ Effective Date: ______________

Policyholder Name: ______________________ Birthdate: ______________

Social Security Number: ______________ Relationship to Patient: ______________

Employer Name: ______________________ Group Number ______________

Policy/ID Number: ______________ Copay Amount ________ or ________% of Visit

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Additional Information

Name of Male Step-parent (if applicable) ______________________

Legal Male Guardian (if applicable): ______________________

Relationship to Patient: ______________________

Name of Female Step-parent (if applicable): ______________________

Legal Female Guardian (if applicable): ______________________

Relationship to Patient: ______________________

Emergency Contact Information

Whom to Call in Case of an Emergency? (Other than parents)

Name: ______________________ Relationship to Patient: ______________________

Telephone: Home: ______________ Work: ______________ Cell: ______________

Signature Required: I hereby authorize SUBURBAN PEDIATRIC ASSOCIATES, INC. (SPA) to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by SPA health care providers and hereby direct my insurance carrier or its intermediaries to issue payment directly to Suburban Pediatric Associates, Inc. on behalf of such rendered services. I understand that I am financially responsible to this office for any balance not covered by my insurance carrier. I further certify that I have had the opportunity to read and/or receive a copy of the **SPA Privacy Policy** document.

______________________________ ______________

Signature **Date**