Pediatrics South

Patient Registration Sheet

Patient Name:		**Patient #:**		**Account #:**
Nickname:		**Pharmacy:**		
Date of Birth:	Age:	Sex:	Primary Language:	
Address:		City:	St:	Zip:
Home Ph.:	Patient Cell	Work:		

RACE: ***(Please review and circle correction if needed)***

AMERICAN INDIAN / ALASKA NATIVE ASIAN BLACK/AFRICAN AMERICAN NATIVE HAWAIIAN
OTHER PACIFIC ISLANDER WHITE MORE THAN ONE RACE REFUSED TO REPORT

ETHNICITY: ***(Please review and circle your correction if needed)***

HISPANIC / LATIN AMERICAN NON-HISPANIC / LATIN AMERICAN REFUSED TO REPORT

Responsible Party:		Sex:	Date of Birth:
Address:		City:	St:	Zip:
	Home Ph.:	Cell:	Work:
E-mail Address:			
Emergency Contact:		Emergency Contact Date of Birth:	
Home Ph.:	Cell Ph.:	Relationship:	

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Carrier Name:	Carrier Name:
Subscriber Name:	Subscriber Name:
Date of Birth:	Date of Birth:
Policy ID:	Policy ID:
Group #:	Group #:
Co-Pay:	Co-Pay:
Effective Date:	Effective Date:

I have read the information above and believe it is correct to the best of my knowledge. Items that were incorrect have been crossed out and corrected. If changes have been made please sign and date below.

Signature of Patient or Responsible Party **Date**