THE PEDIATRICIANS OF HYDE PARK

Patient Registration

Patient Name_________________________ DOB _______________ Primary Physician ________________________

Patient's address__________________________________City__________________St______________Zip____________

Patient's Siblings ____ Sex: Male or Female

Who does patient live with?

Father Mother Both Parents Shared Parenting Grandparents Legal Guardian

Parent ◻ **Father** ◻ **Mother** ◻ **Other** **Parents/Legal Guardian Information**	**Parent** ◻ **Father** ◻ **Mother** ◻ **Other** **Guarantor Information**
Name __________________________________	Name ______________________________
Address ________________________________	Address ____________________________
City State Zip	City State Zip
DOB_________SS#_________________________	DOB__________SS#___________________
Primary number ___________________________	Primary number _________________________
Secondary number ________________________	Secondary# _________________________
Tertiary # _______________________________	Tertiary# __________________________
Employer _______________________________	Employer ___________________________

Primary Insurance	**Secondary Insurance**
Company_______________________________	Company________________________________
Policy # ________________________________	Policy # ________________________________
Group #________________________________	Group # _______________________________
Subscriber DOB _________________________	Subscriber Name_________________________
Subscriber Name_________________________	Subscriber DOB______________________
Choose Patient Relationship to Subscriber: Circle One Child Self Other	**Choose Patient Relationship to Subscriber:** Circle One Child Self Other

Emergency Contact	Name
Patient Relationship	Phone Number:

Preferred Appt. Reminder: *Please Choose One*

Mom Cell- *Text or Email* **Dad** Cell- *Text or Email* Home Phone Email: _________________________________

Signed Date: ____ Date: ____________________

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