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: _________________________

EVELYN C. JOSEPH, MD F.A.A.P. KATHLEEN LAMPING-ARAR, MD, F.A.A.P. EDWARD R. GARVIN, MD, F.A.A.P.
ALYSSA PILJAN-GENTLE, MD, F.A.A.P. ALISSA M. GILBERT, MD, F.A. A.P. KARRY R. WILKES, MD.F.A.A.P,

3666 Paxton Avenue │ Cincinnati, OH │ (513) 871-0684│ (513)871-0705 Fax │www.Pediatriciansofhydepark.com