SEASHORE PEDIATRICS

Patient Registration Form

Patient's Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____/_____/_____ Sex: □ Male □ Female SSN#: _____-_____-_____

Race: _____ Ethnicity: _____ Preferred Language: _____

PARENT/GUARDIAN INFORMATION

Mother/Guardian Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____/_____/_____ SSN#_____-_____-_____ Lives with Patient? Yes / No

Home Phone:(____) _____-_____ Mobile: (_____) _____-_____Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: (____) _____-_____ Marital Status: □ M □ S □ D □ W

Father/Guardian Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____/_____/_____ SSN#_____-_____-_____ Lives with Patient? Yes / No

Mobile: (_____) _____-_____Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: (____) _____-_____ Marital Status: □ M □ S □ D □ W

EMERGENCY CONTACT PERSON (other than either the parent(s) or contact(s) listed above)

Name: _____ DOB: _____/_____/_____ Relationship to Patient: _____

Phone:(_____) _____-_____

Seashore Pediatrics may disclose Medical and Billing Information to this contact: □YES □NO

PERSONS AUTHORIZED TO BRING CHILD IN FOR APPOINTMENTS -OTHER THAN PARENTS

Name: _____ DOB: _____/____/_____ Relationship to patient: _____

Phone:(_____) _____-_____

Name: _____ DOB: ____/_____/_____Relationship to patient: _____

Phone:(_____) _____-_____

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Insured's Name: _____ Insured's Name: _____

Relationship: _____ Relationship: _____

DOB: ____/____/____ SSN#: _____-_____-_____ DOB: ____/____/____ SSN#: _____-_____-_____

Policy #: _____ Policy #: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Phone#:(_____) _____-_____

Signature of Parent/Guardian: _____ **Date:** _____/_____/_____

Employee Signature: _____ **Date:** _____/_____/_____