FOREST HILLS PEDIATRICS

Patient Registration Date: _____/_____/_____

Children's Names	Sex	Birthdate	Race
______________________________	____	_____________	______________ Hispanic/Latino( ) Not Hispanic/Latino ( )
______________________________	_____	______________	_______________ Hispanic/Latino( ) Not Hispanic/Latino ( )
______________________________	_____	_______________	_______________ Hispanic/Latino( ) Not Hispanic/Latino ( )
______________________________	_____	________________	_______________ Hispanic/Latino( ) Not Hispanic/Latino ( )

Preferred Language: ______________________ Do you need an interpreter: yes ( ) No ( )
Religion: _____________________ Preferred Pharmacy: ____________________ Location: ___________________________
Who is your primary care physician at FHP: ____
Emergency Contact Name: ____________________________________ Phone Number: _______________________________
Preferred Contact Method: ( ) Nextgen Portal ( ) Home Phone ( ) Cell Phone
Parents Marital Status: ( ) Married ( ) Divorced ( ) Single ( ) Widowed / Custodial Parent Name: ___________________________
Child/ren resides with: ______________________ Address: ____
If Patient is 18 years old his/her contact phone number: ______________________

Father's Name: ___________________________________ Birthdate: _____________Responsible Party? ( ) Yes ( ) No

Home Address: ____ City: _________________ State: ____ Zip: _____________

Telephone Number, Home: ____________________ Cell: ___________________ Work: ___________________________

Social Security Number: _____- ____- _______ Employer Name: ____

E-mail Address: _______________________________________

Mother's Name: ___________________________________ Birthdate: _____________Responsible Party? ( ) Yes ( ) No

Home Address: ____ City: _________________ State: ____ Zip: _____________

Telephone Number, Home: ____________________ Cell: ____________________ Work: ___________________________

Social Security Number: _____- ____- _______ Employer Name: ____

E-mail Address: _______________________________________ Maiden Name: ______________________________________

If someone other than the parent such as a legal guardian due to foster care, please fill out the following information and provide appropriate documents

Legal Guardian Name: ________________________________ Birthdate: _____________Responsible Party? ( ) Yes ( ) No

Home Address: ____ City: _________________ State: ____ Zip: _____________

Telephone Number, Home: ____________________ Cell: ____________________ Work: ___________________________

E-mail Address: _______________________________________

********PLEASE COMPLETE THE SECOND PAGE OF THIS FORM********

Primary Insurance	Secondary Insurance
Insurance Company Name	Insurance Company Name
Insured Name	Insured Name
Policy #	Policy #
Group #	Group #
Insurance Address	Insurance Address

I further consent that the following individual(s), who may accompany the minor child specified above, may authorize treatment/testing in connection with a prior diagnosis and/or in connection with a new diagnosis and that such individual(s) is authorized to pick up any prescription or medication (including a controlled substance) provided to the minor child. I understand that such authorization does not cover consent to major surgery or any treatment provided outside the offices of Forest Hills Pediatrics, LLC.

STEP FAMILIES

In order for step parents to bring patient to appointments, both parents must sign this form. If one parent has full custody, appropriate documents must be presented.

Name of Male Step-parent: ____

Name of Female Step-parent: ______________________________________

____ ____________________________________

Mother's Signature Father's Signature

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest of confidence and it is my responsibility to inform this office of any change. I authorize your staff to perform the necessary services my child may need. I authorize your staff to file insurance with the appropriate insurance company and the insurance to send payment directly to the physician's office. ***I understand I am responsible for any amount not covered by my insurance.***

Signature of Parent or Guardian: ____ Date: ___________________

Or

Signature of Patient if 18 yrs or older: ____ Date: ___________________