



PATIENT REGISTRATION FORM

Patient Full Legal Name _____ Date of birth _____

Ethnicity: Non-Hispanic Hispanic Not specified Decline to Answer

Race: African or African American. Asian or Asian American. Caucasian or European American. Native American or Native Alaskan. Native Hawaiian or other Pacific Islander. Other race Decline to Answer

PARENT/ GUARDIAN INFORMATION

Name _____ Birth Date _____

Relationship to Child _____

Email (Required) _____

Home Address _____

City _____ State _____ Zip _____

Phone numbers (H) _____ (Cell) _____

INSURANCE INFORMATION/ RESPONSIBLE PARTY

Insurance company _____ Group # _____

Child's ID # _____ Insurance policy holder's name _____

Relationship to child _____

EMERGENCY CONTACT INFORMATION (not living with patient)

Name _____ Relationship _____ Ph # _____

I hereby assign the benefits from any insurance or third party to GENTLE PEDIATRICS PLLC for medical services provided to my child. I understand that GENTLE PEDIATRICS PLLC has the right to decline or accept assignment of such benefits. If these benefits are not assigned to GENTLE PEDIATRICS PLLC, I agree to forward to the practice, upon receipt, any insurance or third-party payments I receive for services rendered to me. I authorize the release of any medical information needed to determine the benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Parent/Guardian Signature _____ Date _____