# TAYLOR PEDIATRICS REGISTRATION FROM

*Today's Date:* _____ *Clinic Name:* _____

*PATIENT INFORMATION: (Please use full legal name, no nicknames please)*

**Last Name:** _____ **First Name:** _____ **Middle Name:** _____

**Address:** _____ **SS#**_____

**City:** _____ **State:** _____ **Zip:** _____

**Home Phone #: (_____)** _____ **Cell Phone: (_____)** _____

**Date of Birth:** _____ **Age:** _____ **Sex: Female [ ] Male [ ]**

**Emergency Contact Name:** _____ **Emerg Phone #: (_____)** _____-_____

*PARENT INFORMATION: (List person or Insured name responsible for bill – use full legal name, no nicknames please)*

****Person responsible for Bill:** _____**Mother** _____**Father** _____**Other** _____

**Other person who can give consent if parents cannot be reached (*MUST BE A RELATIVE*), please provide name and relationship:**

_____

_____

****Mom's First & Last Name:** _____**DOB:** _____ **SS#:**_____

**Mother's Maiden Name:** _____**Mother's Work Phone #**_____

****Dad's First & Last Name:** _____**DOB:** _____ **SS#:**_____

**Married** _____ **Divorced:** _____ **Single:** _____ **Mom's Cell:** _____

**Home Phone #: (_____)**_____-_____ **Dad's Cell:** _____**Dad's Work Phone #**_____

**Address (if different from above)** _____

**Do you like to get e-mail reminder for your child's appointment?** _____ e-mail: _____@_____

**Please provide name of patients siblings:** _____

_____

**INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)**

**PRIMARY INSURANCE:**

****Policy Holder's name :** _____ **Insurance Name:** _____

****Policy Holder's Social Security #:** _____ ****Policy Holder's DOB:** _____

****Policy / ID #:** _____ **Group #:** _____ **Eff Date:** _____

**Insurance Claims Address & Phone:** _____

_____

**SECONDARY INSURANCE:**

****Policy Holder's name :** _____ **Insurance Name:** _____

****Policy Holder's Social Security #:** _____ ****Policy Holder's DOB:** _____

****Policy / ID #:** _____ **Group #:** _____ **Eff Date:** _____

**Insurance Claims Address & Phone:** _____

** Required Fields Please attach a copy of patient's insurance card in addition to completing all information on this form.

_____

**Parent name:**

**Parent signature:**