HEALING CARE
pediatrics

PATIENT REGISTRATION INFORMATION

CHILD'S NAME (LAST, FIRST, M.I.) _____

D.O.B _____ SS# _____ Boy Girl

PRIMARY PH# _____ CELL PH# _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL _____

PHARMACY LOC _____ PH# _____

INSURANCE & GUARANTOR INFORMATION

SUBSCRIBER NAME (LAST, FIRST, M.I.) _____

SUBSCRIBER D.O.B _____ SS# _____

PRIMARY INSURANCE COMPANY _____

MEMBER ID# _____ GROUP ID# _____

SECONDARY INSURANCE COMPANY _____

MEMBER ID# _____ GROUP ID# _____

PARENT / GUARDIAN INFORMATION

FATHER'S NAME (LAST, FIRST, M.I.) _____

D.O.B _____ SS# _____

EMPLOYER _____

☐ Same as above.

PRIMARY PH# _____ CELL PH# _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL _____

HEALING CARE
pediatrics

MOTHER'S NAME (LAST, FIRST, M.I.) _____

D.O.B _____ SS# _____

EMPLOYER _____

☐ Same as above.

PRIMARY PH# _____ CELL PH# _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL _____

EMERGENCY CONTACT

NAME (LAST, FIRST, M.I.) _____

PRIMARY PH# _____ CELL PH# _____

RELATIONSHIP _____

CAN WE DISCLOSE MEDICAL & BILLING INFORMATION TO THIS CONTACT? Yes No

I CERTIFY THAT THE INFORMATION CONTAINED ON THIS FORM IS TRUE AND CORRECT. FURTHERMORE, I UNDERSTAND IT IS MY RESPONSIBILITY AND DUTY TO INFORM HEALING CARE PEDIATRICS SHOULD ANY OF THE ABOVE INFORMATION CHANGE IN THE FUTURE.

PARENT / GUARDIAN NAME _____

SIGNATURE _____

DATE _____