



PATIENT REGISTRATION

CELL NUMBER (TEXT REMINDERS): _____ CARRIER NETWORK: _____ EMAIL: _____

**IF PATIENT IS 14 OR OLDER, PATIENT'S CELL #: NUMBER? _____

PREFERRED NAME: _____ SEX: MALE FEMALE SOCIAL SECURITY #: _____

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____ DATE OF BIRTH: _____

STREET ADDRESS: _____ APT NUMBER: _____

CITY: _____ STATE: _____ ZIP CODE: _____ HOME PHONE: _____

ETHNICITY: _____ RACE: _____ LANGUAGE: _____

PHARMACY: _____ PHARMACY ADDRESS: _____

M	LAST NAME: _____	FIRST NAME: _____	MIDDLE: _____
O	DATE OF BIRTH: _____	SOCIAL SECURITY NUMBER: _____	
T	STREET ADDRESS: _____	APT NUMBER: _____	
H	CITY: _____	STATE: _____	ZIP CODE: _____
E	HOME PHONE: _____	CELL PHONE: _____	WORK PHONE: _____
R	EMPLOYER: _____		

F	LAST NAME: _____	FIRST NAME: _____	MIDDLE: _____
A	DATE OF BIRTH: _____	SOCIAL SECURITY NUMBER: _____	
T	STREET ADDRESS: _____	APT NUMBER: _____	
H	CITY: _____	STATE: _____	ZIP CODE: _____
E	HOME PHONE: _____	CELL PHONE: _____	WORK PHONE: _____
R	EMPLOYER: _____		

PRIMARY INSURANCE: _____ MEMBER ID: _____

SUBSCRIBER NAME: _____ GROUP #: _____ EFFECTIVE DATE: _____

SUBSCRIBER DATE OF BIRTH: _____ SUBSCRIBER SSN: _____

SECONDARY INSURANCE: _____ MEMBER ID: _____

SUBSCRIBER NAME: _____ GROUP #: _____ EFFECTIVE DATE: _____

SUBSCRIBER DATE OF BIRTH: _____ SUBSCRIBER SSN: _____

EMERGENCY CONTACT: _____ HOME PHONE: _____ CELL PHONE: _____

As pediatricians, we wish to provide your child with the best care possible. We may order certain routine laboratory tests and routine vaccinations that we feel are necessary for the maintenance of good health but that may not be covered by your insurance contract. You will be expected to pay for these services in full. We follow the American Academy of Pediatrics guidelines for child health maintenance and will only order a test if we truly believe that it is necessary for your child's health. I, the parent or guardian of the above child do, hereby authorize Acton Road Pediatrics, LLC, and all of its physicians to give to this child immunizations and treatments that such physicians deem necessary for his/her health. I authorize the release of medical information on this child to other physicians and insurance providers as necessary for my child's care and in compliance with federal HIPAA policies. I acknowledge that I am totally responsible for all charges for services rendered to this child including non-covered services. If this account is referred to a collection agency or attorney for collection, I agree to pay all costs of collection. A returned check fee of \$30 applies to all returned checks.

RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____