Growing Up Pediatrics
Patient Registration Form

Please provide an answer to all questions. Today's Date _____

Name _____
First Middle Last Nickname Gender

Address _____
Street City State Zip

Primary Contact Telephone (for appointment reminders, lab results, etc.)

( ) _____ Patient's DOB _____

Mother's Name _____ Father's Name _____

Mother's DOB _____ Father's DOB _____

Mother's Work # _____ Father's Work # _____

Mother's Cell # _____ Father's Cell # _____

Current Living Situation: ____Married ____ Single ____ Divorced ____Other

If custodial living: ____ % with Mom ____ % with Dad ____% Other

Other Children in Home _____ Relationship _____

Other Children in Home _____ Relationship _____

Other Adults in Home _____ Relationship _____

Primary Insurance _____ Insured's Name _____

Group Name/Number _____ Policy/ID Number _____

Responsible Party Name _____ Phone _____

Resp. Party Address _____

Emergency Contact (*if parent cannot be reached*) _____

Address _____ Phone _____
Street City State

How were you referred to our office_____Website_____Friend_____Angie's List Other: _____

Initials: _____ **Financial Consent:** I authorize Growing Up Pediatrics, P.A. to release any medical information necessary to my insurance carrier an effort to obtain reimbursement for services rendered to my child/dependent and hereby authorize direct payment of benefits payable for these services to Growing Up Pediatrics, P.A.

Initials: _____ **Consent to Treat:** I authorize Growing Up Pediatrics, P.A. to provided medical care to my child/dependent that Is necessary and appropriate.

Initials: _____ **Consent for Email:** I hereby authorize Growing Up Pediatrics, P.A. to communicate with me via email.
Email Address:_____

_____ _____
Signature of Parent/Guardian/Legal Representative Date