# F. READ HOPKINS PEDIATRIC ASSOCIATES, INC.
## PATIENT REGISTRATION FORM - TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

| Child's Name First, Middle, Last | Child's Date of Birth | Age | Sex | Place of Birth |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

| Child(ren)'s Address (If P.O. Box, please include Street Address, City, State, Zip Code) | Home Phone |
|---|---|
| | |

**** I elect to receive appointment reminders by : ☐ TEXT ☐ EMAIL**

## PARENT'S INFORMATION

### BIOLOGICAL MOTHER *OR* LEGAL GUARDIAN *(CIRCLE ONE)*

Name _____ Soc. Sec.# ☐☐☐ ☐☐ ☐☐☐☐ Date of Birth _____

Home Address _____ Email Address:

Home Ph: (  ) _____ Work Ph: (  ) _____ Cell Ph: (  ) _____

Employer _____ Occupation _____

Employer's Address _____

### BIOLOGICAL FATHER *OR* LEGAL GUARDIAN *(CIRCLE ONE)*

Name _____ Soc. Sec.# ☐☐☐ ☐☐ ☐☐☐☐ Date of Birth _____

Home Address _____ Email Address:

Home Ph: (  ) _____ Work Ph: (  ) _____ Cell Ph: (  ) _____

Employer _____ Occupation _____

Employer's Address _____

## EMERGENCY CONTACT INFORMATION

**Emergency Contacts (List 2 persons other than parent/legal guardian)**

Name _____ Relationship to patient _____ Ph. # (  ) _____ Cell # (  ) _____

Name _____ Relationship to patient _____ Ph. # (  ) _____ Cell # (  ) _____

## PATIENT'S INSURANCE INFORMATION

Primary Insurance _____ Policy Holder's Name _____ Group # _____

Identification # _____ Effective Date _____ ***Please present copy of insurance card***

Secondary Insurance _____ Policy Holder's Name _____ Group # _____

Identification # _____ Effective Date _____ ***Please present copy of insurance card***

**Which Pharmacy do you use ?** _____

**Name of person completing this form** _____ **Relationship to child** _____

**Signature** _____ **Date** _____

******OFFICE USE ONLY ***** **Reviewed** ***Signature*** _____ ***Date:*** _____

10/2018 Revised