F. READ HOPKINS PEDIATRIC ASSOCIATES, INC.

PATIENT REGISTRATION FORM – PATIENTS 18 YEARS OLD OR OLDER

PATIENT'S INFORMATION

Name: _____ SS# _____ Date of Birth _____ Sex____

Street Address_____

City/State/ZIP _____Email_____ _____

Home Phone _____ Cell Phone_____ Work Phone_____

Employer _____ Occupation _____

Employer's Address _____

Are you a Student? _____ If so, Full-time or Part-time? _____Where? _____

PATIENT'S INSURANCE INFORMATION

Primary Insurance _____ Identification # _____ Group #_____
Policy Holder's Name _____ Policy Holder's Date of Birth _____
Effective Date _____ Policy Holder's Relationship to Patient _____

Secondary Insurance _____ Identification # _____ Group #_____
Policy Holder's Name _____ Policy Holder's Date of Birth _____
Effective Date _____ Policy Holder's Relationship to Patient _____

WHICH PHARMACY DO YOU USE ? _____

Please present copies of all applicable insurance cards.

Person responsible for payment _____ ***Relationship to Patient***_____

EMERGENCY CONTACT INFORMATION

Emergency Contacts (List 2 persons)

Name _____ Relationship to patient _____ _____
Address _____ _____
Home Phone _____ Work Phone_____ Cell Phone_____

Name _____ Relationship to patient _____ _____
Address _____ _____
Home Phone _____ Work Phone_____ Cell Phone_____

Name of Person Completing This Form _____
Signature _____ ***Date*** _____

How did you hear about our practice? Exisiting Patient ___Friend __ Yellow Pages __ Internet__ Other__