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

MOTHER - *(CIRCLE ONE)* BIOLOGICAL/ADOPTIVE/LEGAL GUARDIAN NAME:

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

Home Address _____ Email Address:

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

Employer _____ Occupation _____

Employer's Address _____

FATHER - *(CIRCLE ONE)* BIOLOGICAL/ADOPTIVE/LEGAL GUARDIAN NAME:

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 _____ Phone # _____

Address _____ Cell Phone _____

Name _____ Relationship to patient _____ Phone # _____

Address _____ Cell Phone _____

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:*** _____