Apple-a-Day Pediatrics S.C. Registration Form

(Please print clearly and fill form completely)

PATIENT INFORMATION FOR *ALL* CHILDREN:				
	Child #1	Child #2	Child #3	Child #4
First Name				
Last Name				
Preferred Name				
Date of Birth				
Sex				
Language				
Race				
Ethnicity				

PATIENT ADDRESS:		CHILD LIVES WITH:	
Address:	Apt:	☐ Both Parents	☐ Other
City, State, Zip:		☐ Mother	☐ Father
Primary Phone:	Cell phone: Yes / No	Reminders: ☐ Text Cell	☐ Email

FIRST CONTACT INFORMATION:	SECOND CONTACT INFORMATION:
Name:	Name:
Relationship:	Relationship:
Financially Responsible? Yes / No	Financially Responsible? Yes / No
Address (if different):	Address (if different):
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
OK to leave detailed message? Yes / No	OK to leave detailed message? Yes / No
OK to text cell phone? Yes / No	OK to text cell phone? Yes / No
E-Mail:	E-Mail:
Date of Birth:	Date of Birth:
Social Security #:	Social Security #:
Employer:	Employer:

INSURANCE INFORMATION:	
Insurance Company:	Effective Date:
Policy ID #:	Policy Group #:
Policy Holder Name:	Policy Holder Date of Birth:

ALTERNATIVE GUARDIAN – I authorize the following below to bring my child(ren) listed above to Apple-a-Day Pediatrics for medical care without my express prior authorization		
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
EMERGENCY CONTACT – if parent/guardian is unavailable		
Name:	Relationship:	Phone:

I CONFIRM THAT THE ABOVE INFORMATION IS COMPLETED ACCURATELY:	
Printed Name	Relationship
Signature	Date