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

(Please print clearly and fill form completely) – ***TO BE COMPLETED BY PATIENT***

PATIENT INFORMATION 18 – 22 YEAR OLDS	
LAST NAME:	FIRST NAME:
PREFERRED NAME:	DATE OF BIRTH:
PHONE #:	OK to leave detailed voicemail: Yes / No
EMAIL:	OK to send text messages: Yes / No
LANGUAGE:	**ADDRESS:**
RACE:	
ETHNICITY:	EMPLOYER:

**** I AUTHORIZE APPLE-A-DAY PEDIATRICS TO USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION TO:** (If no names are listed below, information is shared with you ONLY)	
Name:	Relationship:
Name:	Relationship:

PATIENT LIVES WITH			
□ Both Parents	□ On Own	□ Mother	□ Father

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:

EMERGENCY CONTACT		
Name:	Relationship:	Phone:

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

REVISED 3/30/2022