PENSACOLA PEDIATRICS, P.A.

We ask for a lot of information. We need it to give your child the care they need, provide you with information and bill your insurance.

Today's Date:__________ Your primary physician here: ________________________ ID:_________

Patient Last Name: _________________________ Patient's First Name: _______________ Initial: ___

Nickname: _____________ Birth Date: ______________ SS#: ____-___-______ ❑ Male / ❑ Female

Patient Address:(Street)_______________________________________(City)___________________ (State)_____(Zip)________

Primary Phone #: ______-______-_______

Other Children Seen by Us? ❑ YES / ❑ NO

Ethnicity: ❑Hispanic ❑Not Hispanic ❑Declined

Race: ❑ American Indian ❑ Asian ❑Black/African American ❑ Native Hawaiian/Pacific Islander ❑ White ❑ Other ❑ Declined

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Provide ALL contacts: First (who most often brings child), Second and the Insured

First Parent or Guardian Contact *(Circle One)*

Last Name: _________________________________ First Name: ______________________ Initial: ___

Social Security #: ___________________________ Date of Birth: _____________________

Address: (Street)____ (City)____________________ (State)_____(Zip)________

Home Email: ____________________________ Work Email: ________________________________

Employer: ______________________________ Occupation:________ Insurance Holder? ❑ YES / ❑ NO

Primary Phone #: ______-______-_______ Work: ______-______-_________ Cell: ______-______-________

Second Parent or Guardian *(Circle One)*

Last Name: _________________________________ First Name: ______________________ Initial: ___

Social Security #: ___________________________ Date of Birth: _____________________

Address: (Street)____ (City)____________________ (State)_____(Zip)________

Home Email: ____________________________ Work Email: ________________________________

Employer: ______________________________ Occupation:________ Insurance Holder? ❑ YES / ❑ NO

Primary Phone #: ______-______-_______ Work: ______-______-_________ Cell: ______-______-________

INSURED'S Last Name: _______________________ First Name: ______________________ Initial: ___

❑ Male / ❑ Female Birth Date: ______________ Relation to Patient: _________________________

Insurance Carrier: __________________________ Member ID#: ______________________________

Group #:_____________________ Group Name: ______________________ 2nd Insurance? ❑ YES / ❑NO

(If another (secondary) insurance please put information on back)

Patient Balances (co-pays, deductibles, and coinsurance amounts) are due today.

#123 Patient Registration Intake Form 01/2018