BUILDING BLOCKS PEDIATRIC GROUP, LLC – PATIENT REGISTRATION FORM

PATIENT INFORMATION

Full Name: ____ □Female □Male

Address: ______________________ City: _________ State: _____ Zip Code: ________

Telephone: _______________ SS#: _______/______/_______ DOB: ______/______/______

MOTHER'S INFORMATION

First Name: ________________ Last Name: ________________ Middle Initial: _______

Address: ______________________ City: __________ State: _____ Zip Code: ________

Home phone: ____________ Cell phone: ____________ Email address: __________________

SS#: _______/______/_______ DOB: ______/______/______ Marital Status: □S □M □D □W

Employer: _______________________ Work phone: _________ Language: _________

FATHER'S INFORMATION

First Name: ________________ Last Name: ________________ Middle Initial: _______

Address: ______________________ City: __________ State: _____ Zip Code: ________

Home phone: ____________ Cell phone: ____________ Email address: ____________________

SS#: _______/______/_______ DOB: ______/______/______ Marital Status: □S □M □D □W

Employer: _______________________ Work phone: _________ Language: _________

EMERGENCY CONTACT

First Name: ________________ Last Name: ________________ Middle Initial: _______

Address: ______________________ City: __________ State: _____ Zip Code: ________

Home phone: _______________ Work phone: _______________ Cell phone: _______________

Relationship to patient: __________________ Language: ____________________

PREFERRED METHOD OF CONTACT: □MAIL TO HOME □HOME NUM □CELL NUM □WORK NUM

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Name: ______________________________	Insurance Name: ______________________________
Policy Number: ______________________________	Policy Number: ______________________________
Group Number: ______________________________	Group Number: ______________________________
Effective date: ______________________________	Effective date: ______________________________

ETHNICITY	RACE
◻ UNKNOWN	◻ AMERICAN INDIA OR ALASKAN NATIVE
◻ HISPANIC OR LATINO	◻ ASIAN
◻ NOT HISPANIC OR LATINO	◻ BLACK
◻ DECLINED TO ANSWER	◻ HAWAIIAN OR PACIFIC ISLANDER
	◻ WHITE
	◻ DECLINED TO ANSWER

If arrangements have been made for someone other than you, the parent/legal guardian, to accompany your child (i.e., grandparent, aunt, uncle, sibling, etc) to our office, we will need written permission from you for them to sign and authorize medical treatment as deemed necessary by our office as well as have access to your child's confidential medical record. Additionally, they will need to bring with them a valid State ID and your child's insurance information.

1. ______________________________
   (Name and date of birth of relative/friend)
2. ______________________________
   (Name and date of birth of relative/friend)
3. ______________________________
   (Name and date of birth of relative/friend)

The information provided above is complete and accurate to the best of my knowledge. I will advise the office if there is a change in address and/or insurance information.

Signature: ______________________________ Date: ____________________
(Parent name/legal guardian name)