Bee Well Pediatrics

Patient Registration Form

Patient Information

Patient's Name

DOB

Gender

◯ Female ◯ Male

Address | Suite/Apt. # | City | State | Zip

Parent/Guardian First Name | Parent/Guardian Last Name | Parent/Guardian's Relationship to Patient

Mobile Phone | Home Phone | Email

Consent to receive automated calls:

◯ Yes ◯ No

Consent to receive automated Texts

◯ Yes ◯ No

Parent/Guardian Name FIRST NAME AND LAST NAME | Relationship to Patient

Mobile Phone | Home Phone | Email

Is the patient in foster care?

◯ Yes ◯ No

If yes, provide name and phone number of case worker

Emergency Contact Information

Name | Relationship | Phone

Pharmacy Information

Name of your Pharmacy | Phone #

Address, City, State, Zip

Insurance

Do you have insurance?

◯ Yes ◯ No

Insurance Company Carrier Name | Member ID / Policy # | Group ID

Policy Holder's First Name | Policy Holder's Last Name | Policy Holder's Date of Birth | Sex

◯ Male ◯ Female

Please add a picture of your insurance card.

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Do you have additional insurance?

◯ Yes ◯ No

Secondary Insurance Company

Member ID / Policy #

Group ID

Policy Holder's First Name

Policy Holder's Last Name

Date of Birth

Sex

◯ Male ◯ Female

Please add a picture of your insurance card.

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