SOUTH BEACH MEDICAL ASSOCIATES
NEW PATIENT REGISTRATION

Date Completed	
Primary Care Provider	

Patient Registration Form (Please fill in all fields completely)

Patient Information

Child's Full Legal Name (Last, First, Middle)	Date of Birth	Sex	Preferred Name
Other Children in family:			
Child's Street Address (City, State, Zip Code)	Telephone# where child lives	Parent's Work # ☐ Parent #1 ☐ Parent #2	Parent's Email Address: ☐ Parent #1 ☐ Parent #2

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian and other Pacific Islander ☐ White

Ethnic Group: ☐ Hispanic ☐ Non-Hispanic

Patient's Primary Language: ☐English ☐ Spanish ☐ Other

Parent's/Legal Guardian's Primary Language: ☐English ☐Spanish ☐Other-

Does the parent/legal guardian require an interpreter? ☐Yes ☐No

Parent #1's highest level of education : ☐ Some high school ☐ High school diploma or GED ☐ Some college ☐ Bachelor's degree ☐ Graduate degree or higher ☐ Prefer not to answer

Parent #2's highest level of education : ☐ Some high school ☐ High school diploma or GED ☐ Some college ☐ Bachelor's degree ☐ Graduate degree or higher ☐ Prefer not to answer

If there is insurance for child/children, please present the insurance card to the check-in staff.

Emergency Contacts

Parent #1's Name (Last, First, Middle)	Home #	Work #	Cell #
Home Address (City, State, Zip Code) (if different from above)			
Parent #2's Name (Last, First, Middle)	Home #	Work #	Cell #
Home Address (City, State, Zip Code) (if different from above)			
Additional Contact (Last, First, Middle)	Home #	Work #	Cell # (Relationship to Patient)
Home Address (City, State, Zip Code)			

Who may we thank for referring you to our practice?	**Birth Hospital**

Guarantor Information (Person financially responsible)

Name	Relationship to Patient		Emancipated Minor? ☐ Yes ☐ No
Street Address (If different from patient)	City	State	Zip
Date of Birth	Home #	Work #	Cell #
Employer Name	City	State	Zip

Insurance Information (if insurance is provided, please complete the information below)

Insurance Name	Claims Address	Telephone #

Subscriber ID #	Group #	Patient Relationship to Subscriber:
Subscriber's Name		DOB:
Subscriber Address (if different than guarantor)		Subscriber Employer