KinderHealth Patient Registration Form

PATIENT INFORMATION

First Name	Middle	Last Name	Nickname
Date of Birth	Male	Female	
Home Phone Number		Work Phone number	Cell Phone
Address		City	State Zip Code
Emergency contact		Relationship to patient	Phone Number

INSURANCE INFORMATION

Primary Insurance Company Name	Policy Number	Group/Plan Number
Insured's Name	Insured's Date of Birth	Relationship to Patient
Secondary Insurance Company Name	Policy Number	Group/Plan Number
Insured's Name	Insured' Date of Birth	Relationship to patient

SIBILINGS INFORMATION

Name	DOB	Insurance Name : ID Number:
Name	DOB	Insurance Name : ID Number:
Name	DOB	Insurance Name : ID Number:
Name	DOB	Insurance Name : ID Number:
Name	DOB	Insurance Name : ID Number:

PARENTS/GUARDIAN INFORMATION

Responsible Party's Information	**Responsible Party's Information**
Name	Name
Relationship to patient	Relationship to patient
DOB	DOB
Address	Address
E-mail Address	E- mail Address
Home Phone Number Cell Phone Number	Home Phone Number Cell Phone Number
Employer Name Phone Number	Employer Name Phone Number
Patient Lives with:	Patient Referred by:
Are there any legal restrictions regarding custody? ☐NO ☐YES If yes, please explain.	

CMS required

Language other than English			
Ethnicity	☐ Unknown ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline		
Race	☐ American Indian or Alaskan Native ☐Asian ☐ African – American or Black ☐ Hawaiian Native or Pacific Islander ☐ White ☐ Decline		
How would you like to be contacted (mark one)	Home Phone,	Cell Phone,	Work Phone,
☐Medical Issues			
☐Appointments and other Reminders			
☐Come Back to Office Recalls			
☐Billing Status			
☐General Notice	e-mail only		
☐Patient Portal	e-mail only		

Privacy and Billing

I authorize the release of any of my children's medical information needed to process insurance claims and payments. I have been offered a copy of The Notice of Privacy Practice HIPPA.

I fully understand that I am financially responsible for all charges and balances remaining from claims as well as charges denied or not covered by my insurance.

Parent/Guardian or Authorized Representative _____(print name)

Signature_____Date_____