Navesink Pediatrics
Patient Registration

PERSONAL INFORMATION

Patient's Name:

1. ______________________________ DOB ______________ Sex: Male Female (Circle one)
2. ______________________________ DOB ______________ Sex: Male Female (Circle one)
3. ______________________________ DOB ______________ Sex: Male Female (Circle one)
4. ______________________________ DOB ______________ Sex: Male Female (Circle one)

Language: ____________________

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian /Other Pacific Islander ☐ White ☐ Choose not to answer

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Choose not to answer

Address: (Street)______________________________(City/State)________________(Zip)________

Preferred Phone:________________ Cell or Home **Alternate Phone**: ________________ Cell or Home

Parent/Guardian E-mail: ____

Guarantor Name:__________________________ Patient Relationship to Guarantor: ________________

Guarantor Address: (Street) __________________________ (City/State) __________ (Zip) __________

Emergency Contact: ________________________ Phone:__________ Relationship:________________

AKA/Patient Nickname: ______________________ Patient Needs: ______________________________

Parent Name: ____________________________ Parent Name: ______________________________

Referred by: ____

INSURANCE INFORMATION

Primary Insurance Co. Information: (name, address and phone # of person responsible for payment)

Insurance Company Name: ________________________________Phone: ____________________

Policy/ID Number: ____________________Group #: ______________ Effective Date: ______________

Subscriber's Name: __________________________ Relationship to Patient______________________

Subscriber's DOB: ____________ Subscriber's Sex: Male or Female (Circle one)

Address: ____ Phone: ________________

Subscriber's Employer: ____

Secondary Insurance Co. Information: (name, address and phone # of person responsible for payment)

Insurance Company Name: ________________________________ Phone: ____________________

Policy/ID Number: ____________________ Group #: ______________ Effective Date: ______________

Subscriber's Name: __________________________ Relationship to Patient ______________________

Subscriber's DOB: ______________ Subscriber's Sex: Male or Female (Circle one)

Address: ____Phone: ____________________

Subscriber's Employer: ____

I understand that I am financially responsible for all charges whether or not covered by my insurance. I hereby authorize Navesink Pediatrics to release any information necessary to secure payment on my behalf.

Signature: ____ **Date**: ________________