# OLENTANGY PEDIATRICS, INC.

## REGISTRATION FORM

***IF YOU HAVE MORE THAN ONE CHILD AND THEIR REGISTRATION INFORMATION IS <u>DIFFERENT</u> (address, parents, insurance, etc.)***
***<u>PLEASE ASK THE RECEPTIONIST FOR AN ALTERNATE FORM</u>***
***<u>(ex: if you have 2 children with the same information and 2 children with different information, you would fill out this form and the alternate form)</u>***

Legal Guardian Name #1_____Relationship to patient:_____ Home Phone:_____
Work Phone:_____
Address: _____ Cell Phone:_____
City: _____ State: _____ Zip: _____ Date of Birth: _____ SSN#: _____
Email Address: _____ Employer: _____ Occupation: _____

Legal Guardian Name #2_____Relationship to patient:_____ Home Phone:_____
Work Phone:_____
Address: _____ Cell Phone:_____
City: _____ State: _____ Zip: _____ Date of Birth: _____ SSN#: _____
Email Address: _____ Employer: _____ Occupation: _____

Emergency Contact Person: Name:_____ Phone#_____ Relationship to patient:_____
(other than parent)

Parents Marital Status: (circle one) single married separated divorced widowed

If parents are divorced or separated please fill out this section:
Who has custody? _____ Primary parent to contact: _____
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about that child's medical records and/or treatment? _____
If yes, please explain and provide a copy of any legal paperwork that supports this restriction: _____
_____
_____

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Children: (Patients at this office) Please circle:

| Name: | M/F | Date of Birth: | Primary Doctor: |
|---|---|---|---|
| Name: | M/F | Date of Birth: | Primary Doctor: |
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| Name: | M/F | Date of Birth: | Primary Doctor: |
| Name: | M/F | Date of Birth: | Primary Doctor: |
| Name: | M/F | Date of Birth: | Primary Doctor: |

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**INSURANCE/BILLING INFORMATION**

1.) Name of Insurance Company:_____ Policy/ID#_____ Group#_____
Name of person who carries the insurance:_____ Relationship to patient:_____

2.) Name of Insurance Company:_____ Policy/ID#_____ Group#_____
Name of person who carries the insurance:_____ Relationship to patient:_____

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How would you like to receive reminder calls? (circle one) ***Phone*** ***Text*** ***Email***

## OLENTANGY PEDIATRICS, INC
## REGISTRATION FORM

***(THIS FORM ONLY TO BE FILLED OUT IF YOU HAVE MORE THAN ONE CHILD AND THEIR REGISTRATION INFORMATION IS <u>DIFFERENT</u>)***

Child Name: _____ M/F Date of Birth: _____ Primary Doctor: _____

Legal Guardian Name #1_____Relationship to patient:_____ Home Phone:_____
Work Phone:_____
Address: _____ Cell Phone:_____
City: _____ State: _____ Zip: _____ Date of Birth: _____ SSN#: _____
Email Address: _____ Employer: _____ Occupation: _____

Legal Guardian Name #2_____Relationship to patient:_____ Home Phone:_____
Work Phone:_____
Address: _____ Cell Phone:_____
City: _____ State: _____ Zip: _____ Date of Birth: _____ SSN#: _____
Email Address: _____ Employer: _____ Occupation: _____

Child lives with: (circle one) *Mother(s) / Guardian / Stepmother / Foster Mother / Grandmother / Father(s) / Stepfather / Foster Father / Grandfather*

If parents are divorced or separated please fill out this section:
Who has custody? _____ Primary parent to contact:_____
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about that child's medical records and/or treatment? _____
If yes, please explain and provide a copy of any legal paperwork that supports this restriction: _____
_____
_____

Are there step-parents involved? _____

May we speak with them regarding the child listed above regarding medical records, appointments and/or health history? _____

If yes, please provide:

Name: _____ Phone# _____

Emergency Contact Person: Name:_____ Phone# _____ Relationship to patient: _____
(other than parent)

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1.) Name of Insurance Company:_____ Policy/ID# _____ Group# _____
Name of person who carries the insurance:_____ Relationship to patient: _____

2.) Name of Insurance Company:_____ Policy/ID# _____ Group# _____
Name of person who carries the insurance:_____ Relationship to patient: _____

(If an additional child needs to be added, please us the back side of this form. If you need an additional form, please ask the office staff)