PATIENT REGISTRATION

DATE: _____ Physician: _____

CHILD'S FULL LEGAL NAME GENDER Date of Birth LIVES WITH: Patient Phone # (if applicable)*

1. _____ M/F _____ _____ _ _ _- _ _ _ - _ _ _ _

Preferred Language: ☐ English ☐ Spanish OTHER: _____

**As children get older, they will often come by themselves to appointments. Our providers would like a way to get ahold of them if necessary. For patients over the age of 19, unless permission is given to the parent, we will be contacting them directly. Please ask the front desk for a consent form if your child is over 19 and would like to give a parent permission to communicate with our office.*

Parent or Guardian Information

********PLEASE READ: Parent/Guardian information should be the two BIOLOGICAL or LEGAL guardians that we are legally allowed to give medical information to. Please do NOT put step parents, boyfriends, girlfriends etc in this section. See section at bottom of page to add other contact information.***

Parent 1 will receive appointment reminders

Parent/Guardian 1: _____

Relationship to patient: _____

SSN: _____

Birthdate: ___/___/_____ Gender: Male/Female

Marital Status: Married Single Divorced

Address: _____

City: _____ State: _____ Zip: _____

Primary contact phone: ( ) - __ __ __ - __ __ __ __

Work Phone: ( ) - __ __ __ - __ __ __ __

Employer: _____

Email: _____

Parent/Guardian 2: _____

Relationship to patient: _____

SSN: _____

Birthdate: ___/___/_____ Gender: Male/Female

Marital Status: Married Single Divorced

Address the same as Parent 1 ☐

Address: _____

City: _____ State: _____ Zip: _____

Secondary contact phone:( ) - __ __ __ - __ __ __ __

Work Phone: ( ) - __ __ __ - __ __ __ __

Employer: _____

Email: _____

Emergency Contact (other than parents)

Name: _____ Relationship to patient:_____ Phone _ _ _ - _ _ _ - _ _ _ _

IF CHILD HAS A PARENT OTHER THAN THE ONES LISTED ABOVE, PLEASE EXPLAIN:

Other parent name: _____ Relationship:_____

Address: _____ City: _____ State: ____ Zip: _____ Phone _ _ _- _ _ _ - _ _ _ _

Employer: _____ Work Phone: _ _ _- _ _ _ - _ _ _ _ Email: _____

I hereby authorize Lincoln Pediatric Group to release any information acquired in the course of examination to my insurance carrier. This authorization shall remain valid until written notice is given by me revoking said authorization. I further authorize payments made directly to the physician. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Signature: _____ Print Name: _____ Date: _____

OVER

CHECK ANY OF THE FOLLOWING CONDITIONS WHICH OCCUR IN ANY RELATIVE AND STATE THE RELATIONSHIP TO THE CHILD (PLEASE SPECIFY MATERNAL OR PATERNAL)

◯ No changes since last form completed

DISEASE	CIRCLE ONE	Relationship to Child
○ Asthma	Maternal/Paternal	_____
○ Hay Fever/Allergies	Maternal/Paternal	_____
○ Eczema	Maternal/Paternal	_____
○ Lead Poisoning	Maternal/Paternal	_____
○ Blood or Bleeding Disease	Maternal/Paternal	_____
○ Epilepsy/Convulsions	Maternal/Paternal	_____
○ Kidney Disease	Maternal/Paternal	_____
○ Developmental Disabilities	Maternal/Paternal	_____
○ Nervous Condition	Maternal/Paternal	_____
○ Diabetes	Maternal/Paternal	_____
○ Cancer	Maternal/Paternal	_____
○ Depression	Maternal/Paternal	_____
○ Tuberculosis	Maternal/Paternal	_____
○ Stillborn Babies	Maternal/Paternal	_____
○ Miscarriage	Maternal/Paternal	_____
○ Other Inherited Disease	Maternal/Paternal	_____
○ Hearing Loss/Deafness	Maternal/Paternal	_____
○ Thyroid Disease	Maternal/Paternal	_____
○ High Blood Pressure	Maternal/Paternal	_____
○ Birth Defects	Maternal/Paternal	_____
○ Heart Disease	Maternal/Paternal	_____
○ High Cholesterol	Maternal/Paternal	_____
○ Alcoholism	Maternal/Paternal	_____
○ *NONE OF THE ABOVE*		

Does anyone smoke in the home? *(Circle one)* YES NO

This form is to be completed once per year to ensure accurate contact information and family history.