REGISTRATION FORM

Today's Date: ____/____/_____
Previous PMD: _____

PATIENT INFORMATION

NAME: _____ DOB: ____/____/_____GENDER: _____

NAME: _____ DOB: ____/____/_____GENDER: _____

NAME: _____ DOB: ____/____/_____GENDER: _____

NAME: _____ DOB: ____/____/_____GENDER: _____

FAMILY / CONTACT INFORMATION

PARENT/LEGAL GUARDIAN 1

Name: _____ Relationship to Patient: _____

DOB: ____/____/_____ HOME PHONE: _____ CELL PHONE: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

OCCUPATION: _____ EMPLOYER/WORK #: _____

EMAIL: _____ Preferred #: Home / Cell/ Work

PARENT/LEGAL GUARDIAN 2

Name: _____ Relationship to Patient: _____

DOB: ____/____/_____ HOME PHONE: _____ CELL PHONE: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

OCCUPATION: _____ EMPLOYER/WORK #: _____

EMAIL: _____ Preferred #: Home / Cell/ Work

Patient(s) resides primarily with: _____

Parents are: Married / Divorced / Separated / Other: _____
If parents are divorced or separated who has custody? _____
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 the child's medical treatment? YES/NO (If YES, please explain and provide a copy of any legal documents that supports this restriction.)

INSURANCE INFORMATION

Is this patient covered by insurance? YES/NO

PRIMARY INSURANCE: _____ ID #: _____

GROUP #: _____ EFFECTIVE DATE: _____

POLICY HOLDER: _____DOB: ___ /____/_____

SS #: _____ EMPLOYER / WORK #: _____

SECONDARY INSURANCE: _____ ID #: _____

GROUP #: _____ EFFECTIVE DATE: _____

POLICY HOLDER: _____DOB: ___ /____/_____

SS #: _____ EMPLOYER / WORK #: _____

PHARMACY INFORMATION

PHARMACY NAME & LOCATION: _____ PHONE: _____

EMERGENCY CONTACTS

(Other than parents)

NAME: _____ PHONE: _____

NAME: _____ PHONE: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Point Pediatrics, LLC or insurance company to release any information required to process my claims.

I give permission for Point Pediatrics, LLC to contact me via cell phone, text or email.

PARENT/GUARDIAN SIGNATURE: _____ DATE: ___/ ___/_____