Kendall Pediatric Associates Patient Registration Form

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other________________

Patient's Name (Last)______________________________ (First)________________________ (Middle)__________________

Also Known As Name (Last)____(First)______________________________________

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Social Security Number ________-_____-_______ ☐ Female ☐ Male Date of Birth______/______/_______

E-Mail Address____

Phone Numbers Work_____________________ ☐ Day ☐ Evening Home____________________ ☐ Day ☐ Evening

Cellular___________________ Pager____________________

Address____

City, State, ZIP (+4)____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer____ Occupation_____________________________________

Emergency Contact Name____ Phone Number_____________________________

Emergency Contact Relationship to Patient____

Referring Provider Name____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last)______________________ (First)________________________ (Middle)__________________

Also Known As Name (Last)____(First)______________________________________

Social Security Number ________-_____-_______ ☐ Female ☐ Male Date of Birth______/______/_______

E-Mail Address____

Phone Numbers Work_____________________ ☐ Day ☐ Evening Home____________________ ☐ Day ☐ Evening

Address____

City, State, ZIP (+4)____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer____ Employer Phone Number__________________________

Patient Relationship to Responsible Party____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured____ Patient Relationship to Insured______________________

Insured Employer Name____

Insurance Company/Phone Number____ (_______)__________________

Subscriber ID (Policy Number)___________________ Group ID__________________ Copay Amount______________________

Effective Date______________________ Termination Date______________________ ☐ Female ☐ Male

Insured Date of Birth_______/_______/_______ Insured's Social Security Number ________-_____-_______

Insurance Company Address____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured____ Patient Relationship to Insured______________________

Insured Employer Name____

Insurance Company/Phone Number____ (_______)__________________

Subscriber ID (Policy Number)___________________ Group ID__________________ Copay Amount______________________

Effective Date______________________ Termination Date______________________ ☐ Female ☐ Male

Insured Date of Birth_______/_______/_______ Insured's Social Security Number ________-_____-_______

Insurance Company Address____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature____ ***Date***_________________