

Suburban Pediatric Associates, Inc.

PATIENT REGISTRATION FORM

DATE: ___/___/___

New Patient Update

Children's Names Sex Birth date Relationship Patient Social Security #

_____	_____	___/___/___	_____	_____
_____	_____	___/___/___	_____	_____
_____	_____	___/___/___	_____	_____
_____	_____	___/___/___	_____	_____
_____	_____	___/___/___	_____	_____

(If patient is over 18 years of age, we need his/her contact phone number) _____
Name Phone

PREFERRED PHARMACY _____ **ADDRESS:** _____

FAMILY INFORMATION

Father's Name: _____ **Birth date:** _____

Home Address: _____ City: _____ State: _____ ZIP: _____

Telephone: Home: _____ Work: _____ Cell: _____

Employer: _____ Position: _____

E-mail address _____

Mother's Name: _____ **Birth date:** _____

Home Address: _____ City: _____ State: _____ ZIP: _____

Telephone: Home: _____ Work: _____ Cell: _____

Employer: _____ Position: _____

E-mail Address _____

GUARANTOR/RESPONSIBLE PARTY INFORMATION

Name: _____ SSN _____ - _____ - _____

Address: _____ City: _____ State: _____ ZIP: _____

Telephone: Home: _____ Work: _____ Cell: _____

Employer: _____ Position: _____

Employer Address: _____ City: _____ State: _____ ZIP: _____

*****PLEASE COMPLETE SECOND PAGE OF FORM*****

PRIMARY INSURANCE

Ins. Co. Name: _____ Effective Date: ___/___/___
Policyholder Name: _____ Birth date: ___/___/___
Social Security No: _____ - _____ - _____ Relationship to Patient: _____
Employer Name: _____ Group No: _____
Policy/ID No: _____ Co-pay Amount: \$ _____ or _____ % of visit

SECONDARY INSURANCE

Ins. Co. Name: _____ Effective Date: ___/___/___
Policyholder Name: _____ Birth date: ___/___/___
Social Security No: _____ - _____ - _____ Relationship to Patient: _____
Employer Name: _____ Group No: _____
Policy/ID No: _____ Co-pay Amount: \$ _____ or _____ % of visit

ADDITIONAL INFORMATION

Name of Male Step-parent (if applicable): _____
Legal Male Guardian (if applicable): _____
Relationship to Patient: _____
Name of Female Step-parent (if applicable): _____
Legal Female Guardian (if applicable): _____
Relationship to Patient: _____

EMERGENCY CONTACT INFORMATION

Whom to Call in Case of Emergency? (Other than parents)
Name: _____ Relationship to Patient: _____
Telephone: Home: _____ Work: _____ Cell: _____

SIGNATURE REQUIRED

I hereby authorize SUBURBAN PEDIATRIC ASSOCIATES, INC. (SPA) to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by SPA health care providers and hereby direct my insurance carrier or its intermediaries to issue payment directly to Suburban Pediatric Associates, Inc. on behalf of such rendered services. I understand that I am financially responsible to this office for any balance not covered by my insurance carrier. I further certify that I have received, read and agree with the SPA Privacy Policy document.

Signature

Date