EASTSIDE PEDIATRIC GROUP, LLP
PATIENT REGISTRATION FORM
Please Print

Date:_____

Mother's Maiden Name:_____ ***(required for NYS Immunization Registry)***
Mother's Name:_____ DOB:_____ SS#_____(*Required)*
Address_____ City: _____ State: _____ Zip: _____
Marital Status: Single:_____ Married:_____ Divorced / Separated: _____ Widow: _____
Home Telephone Number: _____ Cell Phone Number: _____
Employer: _____ Occupation: _____
Employer's Address: _____ Phone Number: _____

Spouse/Significant Other's Name: _____ DOB: _____ SS#: _____(*Required)*
Spouse/Significant Other's Address:_____ City: _____ State: _____ Zip:_____
Spouse/Significant Other's Home Phone Number: _____ Cell Phone Number: _____
Spouse/Significant Other's Employer/Address: _____
Occupation: _____ Work Phone Number: _____

CHILDREN
Name: _____ M_____ F_____ DOB_____SS#_____
Name: _____ M_____ F_____ DOB_____SS#_____
Name: _____ M_____ F_____ DOB_____SS#_____
Name: _____ M_____ F_____ DOB_____SS#_____
Name: _____ M_____ F_____ DOB_____SS#_____
Name: _____ M_____ F_____ DOB_____SS#_____

EMERGENCY INFORMATION
In the event of an emergency please give us a name and phone number, other than your own, that we may contact.
Name of Emergency Contact:_____
Relationship: _____ Phone Number:_____

INSURANCE INFORMATION
Primary Ins. Co: _____ Subscriber Number:_____
Subscriber's Address (if different from above): _____
Insurance Co. Address: _____
ID#: _____ SS#: _____(*Required)* DOB: _____
Are you covered by another insurance plan? _____ Yes _____ No
If yes, name/address of second ins. co: _____
Subscriber Name: _____ ID#: _____ DOB: _____SS#:_____

****I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for all services rendered. I am also responsible for any reasonable collection fees incurred if my account becomes delinquent. I have read and answered the above questions and certify that the information given is true and correct to the best of my knowledge.**
Signature of Parent: _____ Date:_____

****I acknowledge that I have been given the opportunity to read and/or receive a copy of Eastside Pediatric Group, LLP's Privacy Notice.**
Signature: _____ Date: _____

****I give Eastside Pediatric Group, LLP permission to share/release protected health information of my minor children in the event that I am unable to be reached to the following individuals (please list name and relationship).**
Signature: _____ Date: _____

Name:_____ Name:_____ Name:_____

****I GIVE / DO NOT GIVE (circle one) Eastside Pediatric Group, LLP permission to leave messages on my answering machine regarding appointment reminders and general lab results.**
Signature: _____ Date: _____