PEDIATRIC CARE of KENTUCKY, PSC

PATIENT REGISTRATION

One form may be completed for all children IF the information listed below is the same for all children!

Patient Name: _____DOB_____/_____/_____ Sex __M__F
S.S#: _____/_____/_____ Race_____ Language_____ Primary Care Physician _____
Address: _____ City: _____ State: _____ Zip: _____

Patient Name: _____DOB_____/_____/_____ Sex __M__F
S.S#: _____/_____/_____ Race_____ Language_____ Primary Care Physician _____

Patient Name: _____DOB_____/_____/_____ Sex __M__F
S.S#: _____/_____/_____ Race_____ Language_____ Primary Care Physician _____

Patient Name: _____DOB_____/_____/_____ Sex __M__F
S.S#: _____/_____/_____ Race_____ Language_____ Primary Care Physician _____

Father's Name: _____ DOB _____/_____/_____
S.S #: _____/_____/_____
Address: _____
City: _____ State: _____ Zip: _____
Preferred Contact Phone Number (_____)_____
Alternate Phone Number (_____)_____
Employer:_____ Employer Phone #(_____)_____
E-mail address: _____

Mother's Name: _____ DOB _____/_____/_____
S.S #: _____/_____/_____
Address: _____
City: _____ State: _____ Zip: _____
Preferred Contact Phone Number (_____)_____
Alternate Phone Number (_____)_____
Employer:_____ Employer Phone#(_____)_____
E-mail address: _____

→ **PLEASE COMPLETE OTHER SIDE** →

FOR OFFICE USE ONLY **UPDATED BY:** _____ **DATE:** _____

Responsible Party (if other than parent): _____

DOB _____/_____/_____ S.S #: _____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Contact Phone Number (____)_____

Alternate Phone Number (____)_____

Relationship to patient: ☐ Step-Parent ☐ Self ☐ Other_____

Employer Name: _____Phone #: (_____)_____

Social Worker's Name _____ Phone #: (_____)_____

NAME OF PRIMARY INSURANCE: _____

Subscriber Name: _____ **Subscriber D.O.B**. _____

Subscriber ID/Policy #: _____Group # / Name: _____

Relationship to patient: ☐ Step-Parent ☐ Self ☐ Other_____

PLEASE PRESENT CHILD'S INSURANCE CARD SO IT CAN BE COPIED!

NAME OF SECONDARY INSURANCE: _____

Subscriber Name: _____ **Subscriber D.O.B**. _____

Subscriber ID/Policy #:_____**Group # / Name**_____

Relationship to patient: ☐ Step-Parent ☐ Self ☐ Other_____

PLEASE PRESENT CHILD'S INSURANCE CARD SO IT CAN BE COPIED!

CONSENT TO TREAT

I/We authorize Pediatric Care of Kentucky to treat the child(ren) identified in the Patient Registration section.

Parent / Legal Guardian Signature _____Date: _____

EMERGENCY PHONE NUMBER (other than parents / legal guardian)

Name _____Relationship to Patient _____ Phone # (____)_____

Name _____Relationship to Patient _____ Phone # (____)_____