

# 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 # (\_\_\_\_)** \_\_\_\_\_