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 (_____)______________ □ Cell Number / □ Home Number
Alternate Phone Number (_____)______________ □ Cell Number / □ Home Number
Employer:__________________________ Employer Phone #(______)______________
E-mail address: ____

Mother's Name: ______________________________ DOB ______/_____/_______
S.S #: _________/______/_______
Address: ____
City: ______________________________ State: ______________ Zip: __________
Preferred Contact Phone Number (_____)______________ □ Cell Number / □ Home Number
Alternate Phone Number (_____)______________ □ Cell Number / □ Home 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 (____)__________ □ Cell Number / □ Home Number

Alternate Phone Number (____)__________ □ Cell Number / □ Home 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: □ Parent □ Step-Parent □ Self □ Other__________

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

NAME OF SECONDARY INSURANCE: ____________________

Subscriber Name: ____________________ **Subscriber D.O.B.** __________

Subscriber ID/Policy #:____________________**Group # / Name**__________

Relationship to patient: □ Parent □ Step-Parent □ Self □ Other__________

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

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 # (___)**__________