VERO BEACH PEDIATRICS

NEW PATIENT REGISTRATION

Primary Parent/Guardian Information

Parent/Guardian Name: _____ DOB _____Sex: ___

Relationship to patient _____ Lives with patients below ____ SSN_____

Primary address _____

City _____State _____ Zip _____

Primary phone _____ Work phone _____ Cell phone _____

Employer: _____ Occupation _____

Personal e-mail _____

Pharmacy name: _____Phone: _____ Fax: _____

Preferred contact method for:

Medical issues _____ Reminders _____ Recalls _____

Billing statements _____ General notices _____ Patient Portal _____

Secondary Parent/Guardian Information (optional)

Parent/Guardian Name: _____ DOB _____Sex: ___

Relationship to patient _____ Lives with patients below ____ SSN_____

Primary address _____

City _____State _____ Zip _____

Primary phone _____ Work phone _____ Cell phone _____

Employer: _____ Occupation _____

Personal e-mail _____

Pharmacy name: _____Phone: _____ Fax: _____

Preferred contact method for:

Medical issues _____ Reminders _____ Recalls _____

Billing statements _____ General notices _____ Patient Portal _____

VERO BEACH PEDIATRICS

Child 1

Patient/Child Name: _____ DOB: _____ Sex: ___

Primary address _____

City _____ State _____ Zip _____

Emergency contact: _____

Primary phone _____ Personal email address _____

Language _____ Ethnicity _____ Race _____

Child 2

Patient/Child Name: _____ DOB: _____ Sex: ___

Primary address _____

City _____ State _____ Zip _____

Emergency contact: _____

Primary phone _____ Personal email address _____

Language _____ Ethnicity _____ Race _____

Child 3

Patient/Child Name: _____ DOB: _____ Sex: ___

Primary address _____

City _____ State _____ Zip _____

Emergency contact: _____

Primary phone _____ Personal email address _____

Language _____ Ethnicity _____ Race _____

Child 4

Patient/Child Name: _____ DOB: _____ Sex: ___

Primary address _____

City _____ State _____ Zip _____

Emergency contact: _____

Primary phone _____ Personal email address _____

Language _____ Ethnicity _____ Race _____

Primary Insurance

Subscriber's Name: _____ DOB _____ Sex: ___

Subscriber ID#: _____ Patient relationship to subscriber _____

Insurance carrier _____ Group #: _____ Group name: _____

Authorized persons other than parent/guardian

Persons other than parent/guardian who are authorized to accompany child to appointment include:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Note: These persons are required to bring photo ID on the day of the appointment