Advanced Pediatrics Group
Patient Registration

Childs Name: _____

DOB: ___/____/____ SEX: ____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown

Race: Asian / Black / Hawaiian / White

Mailing Address:

_____

(Street or PO Box) (City) (State & Zip)

Home Phone: (___) _____ - _____

Who Lives at this household?

_____

Insurance:

Primary Policy Holder's Name: _____
Policy Holder's Birth Date: ___/____/____ Policy Holder's Sex: Male/Female
Insurance Carrier: _____
ID #: _____ Group # _____

Secondary Policy Holder's Name: _____
Policy Holder's Birth Date: ___/____/____ Policy Holder's Sex: Male/Female
Insurance Carrier: _____
ID #: _____ Group # _____

Parent/Guardian 1

Name: _____Relation to Patient:_____

Lives with Patient? Yes / No DOB: ___ / ____ / _____ SSN: ____ - _____ - _____

Cell Phone (_____) _____-_____ Work Phone (_____) _____-_____

Home email: _____ Work email _____

Employer: _____ Occupation: _____

How would you ideally prefer to be contacted regarding (Circle One)

Medical Issues: Home Phone / Work Phone / Cell Phone / Home Email

Appointments Remainders: Home Phone / Work Phone / Cell Phone / Home Email

Billing Statements: Home Phone / Work Phone / Cell Phone / Home Email

General Practice Notice: Home Phone / Work Phone / Cell Phone / Home Email

Patient Portal Notifications: Home Phone / Work Phone / Cell Phone / Home Email

Parent/Guardian 2

Name: _____ Relation to Patient: _____

Lives with Patient? Yes / No DOB: ___ / ____ / _____ SSN: ____ - _____ - _____

Cell Phone (_____) _____-_____ Work Phone (_____) _____-_____

Home email: _____ Work email _____

Employer: _____ Occupation: _____

Besides the parents whom do you give permission to receive medical information?

Name: _____ DOB____/____/_____

Relationship to Patient_____ Phone number: (_____) _____-_____

Additional Contact Questions:

Who should receive billing statements?

Name _____ Relationship to Patient _____

If parents are Divorced or separated please fill out this section:

Who has Custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? YES/ NO

If YES please explain and provide a copy of any legal paperwork that supports this restriction

---

Emergency Contacts, OTHER THAN PARENTS: Name & Relationship

1. Name_____

Relationship: _____ Phone Number: (_____) _____-_____

2. Name_____

Relationship: _____ Phone Number: (_____) _____-_____

Please select your PCP:

____ Stephanie dos Santos, MD, FAAP

____ Roger Rivera, MD, FAAP

Parent signature _____ Date _____/_____/_____