

Registration Form

Patient Name _____ Sex Male / Female Birth Date _____

Primary Language _____ **Secondary Language** _____

Country _____ **Country** _____

Ethnicity: _____ Spanish/Hispanic _____ Not of Spanish/Hispanic _____ Declined/Unknown

Ancestry: _____ Asian _____ American Indian/ Alaska Native
_____ Black/ African American _____ Native Hawaiian/Pacific Islander
_____ White _____ Other _____ Declined/Unknown

Address _____ **Phone no.** (_____) _____

City _____ **State** _____ **Zip code** _____

Mother's Name and Address

Father's Name and Address

(_____) _____
Maiden Name

Birth Date _____

Birth Date _____

Home Phone (_____) _____
Cell Phone (_____) _____

Home Phone (_____) _____
Cell Phone (_____) _____

Employer

Employer

(_____) _____
(phone number)

(_____) _____
(phone number)

I am 18 yrs of age or older and hereby authorize Genesee-Transit Pediatrics to release information to: MOTHER () FATHER () N/A ()

Relationship between Mother and Father ___ married ___ separated ___ divorced other _____

Who has legal custody of this patient? _____

What pharmacy do you typically use? _____

(_____) _____
(phone number)

Insurance Information

I am still covered under my parent's insurance: N/A Yes No - I have my own coverage

Primary Insurance Company _____ **Policy #** _____ **Group #** _____

Name of Subscriber _____ **Birth Date** _____

Secondary Insurance Company _____ **Policy #** _____ **Group #** _____

Name of Subscriber _____ **Birth Date** _____

I hereby request and authorize Genesee-Transit Pediatrics to provide and perform such medical / surgical care, tests, procedures, medications, and other healthcare services as are considered necessary or beneficial for me/my child's health and well being. I further authorize (where applicable) the following relatives / friends to bring my child in for healthcare if I am not available.

(Signature of Legal Guardian) _____ **Date** _____

1) _____ / _____ 2) _____ / _____
Emergency Contact (Relationship to patient) (phone number) **Emergency Contact** (Relationship to patient) (phone number)