WOODS MILL PEDIATRICS

WASHINGTON UNIVERSITY CLINICAL ASSOCIATES

Patient Registration

Child's Last Name: _____ **First Name:** _____
Sex _____ Date of birth(s): _____
Additional Children and Date of Birth:
_____
_____
Adopted? Yes No please specify which child(ren) _____

Primary Billing Address:
_____
(Street or PO Box) (City) (State & Zip)

Primary Phone Number: _____ Cell phone: _____

Primary Language spoken in the home? _____
Ethnicity: Hispanic? Yes or No
Race: Asian / Black / Hawaiian / White

Parent 1: Name: _____ Date of birth: _____
Relationship: _____ Genetic? Yes No Stepparent? _____
Work phone _____ Cell: _____
Parent's email: _____ work email: _____
Employer: _____Occupation: _____
Lives with patient (circle one)? Yes No

Parent 2: Name: _____ Date of birth: _____
Relationship: _____ Genetic? Yes No Stepparent? _____
Work phone _____ Cell: _____
Parent's email: _____ work email: _____
Employer: _____Occupation_____
Lives with patient (circle one)? Yes No

Emergency Contact, other than parents: Name & Relationship
1: _____Relationship:_____ph#:_____
2: _____ Relationship: _____ph#:_____

Pharmacy Information:
Pharmacy Name: _____ Zip Code _____
Pharmacy Phone Number: _____

WOODS MILL PEDIATRICS

WASHINGTON UNIVERSITY CLINICAL ASSOCIATES

Patient Registration

Child's Name: _____ **Date of Birth:** _____

Insurance:
Primary Insurance: _____
Policy Holder's Last Name: _____
First Name & Middle Initial: _____
Policy Holder's Birth Date: _____ Social Security Number: _____
ID# _____ Group # _____

Secondary Insurance: _____
Policy Holder's Last Name: _____
First Name & Middle Initial: _____
Policy Holder's Birth Date: _____ Social Security Number: _____
ID#: _____ Group #: _____

Billing statements (If different from above):
Name _____
Relationship to patient _____
Social security # _____
Lives with patient (circle one)? Yes No
Address: _____
Phone: _____

Privacy Constraints (Check One):
____ No restrictions. Okay to leave message / send mail.
____ Restrictions – Person to person with patient / guardian only.
____ Restrictions: _____

How would you ideally prefer to be contacted regarding (circle one):
Medical issues: Home Phone / Work Phone / Cell Phone
Appointment Reminders: Home Phone/Cell Phone
***Recall*:** Home Phone / Work Phone
General Notices: Home Phone / Work Phone / Cell Phone

Please complete this section:
Who has custody? Exclusive Mother ____ Exclusive Father ____ Joint ____
Other Guardian ___
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.