Pediatric Associates

Family Registration

Preferred Doctor: _____ **Referred by:** _____

Preferred Pharmacy:

Preferred Pharmacy: _____ Street: _____
City, State: _____ Phone: _____

Patient Information:

Patient's Name: _____ Gender: _____ Pref. or Nickname: _____
Date of Birth: _____ Home Phone: _____
Address: _____ Cell Phone: _____ *Child / Mother / Father*
_____ Cell Phone: _____ *Child / Mother / Father*

Race 1:

- ☐ American Indian / Alaska Native
- ☐ Asian
- ☐ Black / African American
- ☐ Nat Hawaiian / Pacific Islander
- ☐ White
- ☐ Other race
- ☐ Unknown
- ☐ Decline

Race 2:

- ☐ American Indian / Alaska Native
- ☐ Asian
- ☐ Black / African American
- ☐ Nat Hawaiian / Pacific Islander
- ☐ White
- ☐ Other race
- ☐ Unknown
- ☐ Decline

Ethnicity:

- ☐ Hispanic / Latino
- ☐ Not Hispanic / Latino
- ☐ Unknown
- ☐ Decline

Parent Information:

Parent #1 / Financially responsible: _____ Maiden Name: _____
Relationship to patient: _____ DOB: _____
Employer: _____ Occupation: _____
Email address: _____ Home Phone: _____
Address if different from child: _____ Cell Phone: _____
_____ Work Phone: _____

Parent #2: _____ Maiden Name: _____
Relationship to patient: _____ DOB: _____
Employer: _____ Occupation: _____
Email address: _____ Home Phone: _____
Address if different from child: _____ Cell Phone: _____
_____ Work Phone: _____

How would you like to be contacted? _____

Other children:

Names:	DOB:	Sex:	Names:	DOB:	Sex:
_____	/ /	M / F	_____	/ /	M / F
_____	/ /	M / F	_____	/ /	M / F
_____	/ /	M / F	_____	/ /	M / F
_____	/ /	M / F	_____	/ /	M / F