



## Apple-a-Day Pediatrics Registration Form

PATIENT INFORMATION FOR CHILDREN UNDER THE AGE OF 18 YEARS:			
First Name		Language	
Last Name		Race(s)	
Preferred Name		Ethnicity: Hispanic or Non-Hispanic	
Date of Birth		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Patient Email (12 yr +)

PATIENT ADDRESS:		CHILD LIVES WITH:	
Address:	Apt:	<input type="checkbox"/> Both Parents - Same House	<input type="checkbox"/> Both Parents Separate Houses
City, State, Zip:		<input type="checkbox"/> Other	<input type="checkbox"/> Mother <input type="checkbox"/> Father

PRIMARY CONTACT INFORMATION:		SECONDARY CONTACT INFORMATION:	
Name:		Name:	
Relationship:		Relationship:	
Financially Responsible? Yes / No		Financially Responsible? Yes / No	
Address (if different):		Address (if different):	
Home Phone:		Home Phone:	
Cell Phone:		Cell Phone:	
OK to leave a detailed message? Yes / No		OK to leave a detailed message? Yes / No	
OK to text this cell phone? Yes / No		OK to text this cell phone? Yes / No	
E-Mail:		E-Mail:	
Date of Birth:		Date of Birth:	
Social Security #:		Social Security #:	
Employer:		Employer:	

INSURANCE INFORMATION:	
Insurance Company:	Effective Date:
Policy ID #:	Policy Group #:
Policy Holder Name:	Policy Holder Date of Birth:

**ALTERNATIVE GUARDIAN – ALL patients under the age of 18 years old MUST be accompanied by an adult for all appointments.** If you, the parent/legal guardian, are unable to bring your child to the appointment, please complete the Alternative Guardian Form to authorize someone else to bring in your minor child for their visits.

EMERGENCY CONTACT – if parent/guardian is unavailable		
Name:	Relationship:	Phone:

I CONFIRM THAT THE ABOVE INFORMATION IS COMPLETED ACCURATELY:	
Printed Name:	Relationship:
Signature:	Date: