❑ Update address
❑ Update insurance

Capital Area Pediatrics

Registration Information - Please Print Date: _____ Acct# _____

Patient's Legal Name (First, Middle Initial, Last):		Mother's Maiden Name:	
Nickname:		Patient's Sex Male ☐ Female ☐	Date of Birth:
Address			Apt/Unit #
City	State		Zip Code (9 digits)
Home Telephone	Emergency Contact Name	Relationship ☐ Mother ☐ Father ☐ _____	Emergency Contact Phone
Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Declined ☐ Unknown		Preferred Language: ☐ English ☐ Spanish ☐ Other _____	
Race: ☐ Black/African American ☐ Asian ☐ White ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander ☐ Unkown ☐ Decline			

As a service to our clients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

❑ Mother ❑ Stepmother ❑ Legal Guardian ❑ Address same as Patient's

Full Name		Date of Birth	SSN
Home Address		City	State/Zip
Home Phone	Cell Phone	Email	
Employer Name& Address		Occupation	Work Phone Number

❑ Father ❑ Stepfather ❑ Legal Guardian ❑ Address same as Patient's

Full Name		Date of Birth	SSN
Home Address		City	State/Zip
Home Phone	Cell Phone	Email	
Employer Name& Address		Occupation	Work Phone Number

INSURANCE INFORMATION:

Primary Insurance Company Name: (Copy of insurance card requested)		Effective Date
Name of Subscriber	Subscriber's Date of Birth	Subscriber's Sex ☐ Male ☐ Female
Policy Identification Number	Group Number	Employer
Subscriber's Address (if different from patient's)		
Secondary Insurance Company Name: (Copy of insurance card requested)		Effective Date
Name of Subscriber	Subscriber's Date of Birth	Subscriber's Sex ☐ Male ☐ Female
Policy Identification Number	Group Number	Employer
Subscriber's Address (if different from patient's)		

ADDITIONAL PARENTAL INFORMATION:

If child does not live with parent(s): Name of Legal Guardian(s)		
If the child resides in more than one residence, we are required to know who has legal authority to authorize healthcare services for the child. If child has additional parental support, please indicate below, step-parents names and authorization status.		
Step-Mother's Name	Legally authorized to seek healthcare services for child? ☐ YES ☐ NO	Lives with child at address listed above? ☐ YES ☐ NO
Step-Father's Name	Legally authorized to seek healthcare services for child? ☐ YES ☐ NO	Lives with child at address listed above? ☐ YES ☐ NO
Name of additional Person(s) (grandparent, nanny, or significant other) authorized to seek healthcare services for child. We will also require written authorization.		