Riverside Pediatrics Patient Registration Form

Child's Name: ____

First Middle Last

Preferred name: ______________________ **Gender**: ☐ M ☐ F

Date of Birth: _____/______/_________ Place of Birth: ______________________________

Month Day Year City and State

Home Address: ____

Street City State Zip

Parent 1 Name: ______________________ DOB: ___/____/____ SS#____________________

Occupation: ____________________ Employer: ______________________________

Home Phone #: ______________ Cell # ________________ Work #____________________

Email: ____________________________ Contact Preference: ☐ Home ☐ Work ☐ Cell ☐ Mail

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Parent 2 Name: ______________________ DOB: ___/____/____ SS#____________________

Occupation: ____________________ Employer: ______________________________

Home Phone #: ______________ Cell # ________________ Work #____________________

Email: ____________________________ Contact Preference: ☐ Home ☐ Work ☐ Cell ☐ Mail

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Primary Insurance: ________________________ Policy # ________________________

Policyholder's Name: ________________________ DOB ____/_____/_____ SS#__________________

Patient's relationship to guarantor: ________________________

Secondary Insurance: ________________________ Policy # ________________________

Policyholder's Name: ________________________ DOB ____/____ /____ SS# __________________

Siblings' Names and Dates of Birth (brothers, sisters)

1.______________________ DOB: __________ 4. ______________________ DOB: ________

2.______________________ DOB: __________ 5. ______________________ DOB: ________

3.______________________ DOB: __________ 6. ______________________ DOB: ________

Emergency contact: ______________________ __________________ Phone # ______________

(Other than above) Name Relationship

For all children - Medication History Authority (can we obtain medication history from your pharmacy): ☐Yes ☐ No

Consent to Call (in person/automated): ☐ Yes ☐ No **Consent to Text** (you may receive texts from the office): ☐ Yes ☐ No

Has the "Notice of Privacy Practices" been made available to you: ☐ Yes ☐ No

PLEASE COMPLETE PAGE TWO FOR CHILD AND EACH SIBLING

PAGE 2 (PLEASE COPY AND COMPLETE THIS PAGE FOR EACH OF YOUR CHILDREN)

Child's Birth and Development History:

Child's Name: ____ DOB: ____________

Preferred Provider: ☐ Dr. Elias ☐ Dr. Steffen ☐ Beka Hanna, PNP ☐ No preference (please assign)

The Federal Government requires medical practices to collect the following information. **There is a provision in the law that allows patients to not answer these questions.** Please answer the following three questions or select the "I decline to provide this information" answer.

1. My Ethnicity is: (Please check one answer) ☐ Hispanic ☐ Not Hispanic or Latino

2. My Race is: (Please check one answer) ☐ American Indian/Alaskan Native ☐ Asian
   ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White/Caucasian
   ☐ Other

3. My Preferred Language is: ☐ English ☐ Spanish ☐Other ____________________

☐ **I decline to provide this information**

Who else has permission to bring this child to Riverside Pediatrics and authorize treatment?

Name: ________________________ Relationship: ____________ Phone #: ___________

Name: ________________________ Relationship: ____________ Phone #: ___________

Name of person filling out this form: ____

Signature: ____ Date: _____________