

Stepping Stones Pediatrics Patient Registration Form

Today's Date ___ / ___ / ___

PATIENT INFORMATION (Please use legal name, no nicknames)

Last Name _____ First Name _____ Middle Name _____
Address _____ Apt _____ City _____ State _____ Zip _____
Date of Birth ___ / ___ / ___ Social Security Number _____ - _____ - _____ Sex: ___ Female ___ Male
Home Phone _____ - _____ - _____ Cell Phone _____ - _____ - _____
Emergency Contact Name: _____ Emerg Contact Phone _____ - _____ - _____

FAMILY INFORMATION (Please use legal name, no nicknames)

MOTHER:

Last Name _____ First Name _____ Maiden Name _____
Address _____ Apt _____ City _____ State _____ Zip _____
Date of Birth ___ / ___ / ___ Social Security Number _____ - _____ - _____ Sex: ___ Female ___ Male
Home Phone _____ - _____ - _____ Work Phone _____ - _____ - _____ Cell Phone _____ - _____ - _____
Marital Status: ___ Single ___ Married ___ Divorced

FATHER:

Last Name _____ First Name _____
Address _____ Apt _____ City _____ State _____ Zip _____
Date of Birth ___ / ___ / ___ Social Security Number _____ - _____ - _____ Sex: ___ Female ___ Male
Home Phone _____ - _____ - _____ Work Phone _____ - _____ - _____ Cell Phone _____ - _____ - _____
Marital Status: ___ Single ___ Married ___ Divorced

AUTHORIZATION: I hereby authorize my child to receive care with the following person in my absence: (*relative only*)
Name _____ Relationship to patient _____

SIBLINGS:

Name(s) of patient's siblings _____

INSURANCE/PAYMENT INFORMATION

Who is the person responsible for the bill? ___ Mother ___ Father ___ Other _____

PRIMARY INSURANCE:

Policy Holder's Name _____ Insurance Name _____
Policy Holders SS# _____ - _____ - _____ Policy Holder's Date of Birth ___ / ___ / ___
Policy ID _____ Group # _____ Effective Date ___ / ___ / ___

SECONDARY INSURANCE:

Policy Holder's Name _____ Insurance Name _____
Policy Holders SS# _____ - _____ - _____ Policy Holder's Date of Birth ___ / ___ / ___
Policy ID _____ Group # _____ Effective Date ___ / ___ / ___