KENWOOD PEDIATRICS REGISTRATION FORM

Today's Date: _____
PATIENT INFORMATION: PLEASE USE FULL LEGAL NAME, NO NICKNAMES.

Last Name: _____ First Name:_____ Middle:_____

Date of Birth:_____ Gender: Female:_____Male:_____

Ethnicity: _____ Hispanic/Latino _____ Not Hispanic/Latino _____ Other _____ Decline/Unknown

Race: _____ White _____ Black/African American _____ American Indian/Alaska Native _____ Asian
_____ Native Hawaiian/Other Pacific Islander _____ All Other Races _____ Decline/Unknown

Primary Language: _____

Address:_____ City:_____

State:_____ Zip:_____

Home/Cell Number: (____)_____ Home/Cell Number: (____)_____

Pharmacy Name: _____ Pharmacy Number: (____)_____

Emergency Contact Name: _____ Emergency Number: (____)_____
PARENT(S)/GUARDIAN INFORMATION: PLEASE USE FULL LEGAL NAME, NO NICKNAMES.

Mother's First and Last Name: _____ DOB: _____

Mother's Maiden Name: _____ Mother's Home/Cell Number: (____)_____

Mothers Work Number: (____)_____

Mother's Address (if different from above): _____

Father's First and Last Name: _____ DOB: _____

Father's Home/Cell Number: (____)_____ Father's Work Number: (____)_____

Father's Address (if different from above): _____

Married: _____ Divorced: _____ Single: _____

Person Responsible for the bill: Mother: _____ Father: _____ Other-Name/Relationship:_____

Other person(s) who can give consent: Name _____ Relationship to patient_____
INSURANCE INFORMATION: PLEASE GIVE INSURANCE CARD(S) AND PHOTO ID TO RECEPTIONIST
PRIMARY INSURANCE:

Insurance Name and Address:_____

Policy Holder's Name: _____Relationship to Patient: _____

Policy Holder's DOB: _____ Effective Date: _____

Policy or ID #: _____Group #:_____

SECONDARY INSURANCE:

Insurance Name and Address: _____

Policy Holder's Name: _____Relationship to Patient: _____

Policy Holder's DOB: _____ Effective Date: _____

Policy or ID #: _____ Group #: _____

Please be aware we will not be able to see you unless Dr. Dimitroff is listed as the primary provider. Please take care of this before your appointment. Thank you.