RIDGEFIELD PEDIATRIC ASSOCIATES, P.C.
CHILD/PATIENT REGISTRATION FORM – 2010

Patient's Legal Name: _____
First MI Last

Address: _____ City/State/Zip _____

Home Phone _____ Date of Birth _____ Sex: ___M ___F

Patient's cell # _____
(Age 13 yrs. & over)

E-mail Address: _____

Have you notified your insurance company of your choice of physician? _____Yes _____ No

Siblings: 1: _____ D.O.B. _____

2: _____ D.O.B. _____

3: _____ D.O.B. _____

Parent #1 Name: _____

Address: _____

Marital Status: ____ S ____M ____W ____D Cell #: _____

Employer _____ Work #: _____

Parent Date of Birth: _____

Parent #2 Name: _____

Address: _____

Marital Status: ____ S ____M ____W ____D Cell #: _____

Employer _____ Work #: _____

Parent Date of Birth: _____

All information requested on this form is necessary to submit to your Insurance Company. If sections are left **blank/incomplete**, we will not be able to submit your claim. Therefore you will be required to pay at the time of the visit.

January 2010
AMW