Baptist Pediatrics

Patient Registration & Insurance Information

Please present insurance card and photo ID for us to copy.

Date _____ Physician _____

Person Responsible for Bill

Guarantor Name _____

Address _____

City, State, ZIP _____

Home Phone # _____ Work Phone # _____

Relation to Patient _____ Guarantor Email _____

Patient Information

Name _____

Address _____

City, State, ZIP _____

Home Phone # _____ Work Phone # _____

Cell Phone # _____ Email _____

Date of Birth _____ Sex _____ Marital Status _____

Race: ❑ Black, African American ❑ Asian ❑ White ❑ American Indian, Alaska Native
❑ Native Hawaiian, Other Pacific Islander ❑ Unknown ❑ Declined

Ethnicity: ❑ Hispanic or Latino ❑ Not-Hispanic or Latino ❑ Unknown ❑ Declined

Primary Language _____

Social Security Number _____

(If a minor): Mother's Name _____ Home Phone # _____

Father's Name _____ Home Phone # _____

Emergency Contact Information

Contact Name _____

Relationship to Patient _____

Address _____

City, State, ZIP _____

Home Phone # _____ Work Phone # _____

Primary Insurance Name

Insurance Name _____

Group # _____ Policy # _____

Subscriber Name _____

Patient Relation to Subscriber _____ Date of Birth _____

Social Security Number _____

Employer _____ Work Phone # _____

Secondary Insurance Name

Insurance Name _____

Group # _____ Policy # _____

Subscriber Name _____

Patient Relation to Subscriber _____ Date of Birth _____

Social Security Number _____

Employer _____ Work Phone # _____

Referred by _____