# PEDIATRICS REGISTRATION FORM

(12 Years or Younger)

☐New ☐Renewal ☐ Address Change

**Today's Date:** ____/____/____

**Child's Name:** _____ **MI:** ___ **DOB:** ___/___/___ **Birth Gender:** ☐ Male ☐ Female **SSN:** ____-____-____

**Language: English?** ☐ Yes ☐ No **(if no, Other Language):** _____ **Need a translator?** ☐ Yes ☐ No

**Street Address:** _____ **City:** _____ **State:** _____ **Zip Code:** _____**Ward:** ____

| | |
|---|---|
| **Parent/Guardian Name:** _____**MI:** ____ | **Second Parent/Guardian Name:** _____ **MI:** ___ |
| **Phone #:** _____ **Alternate Phone #:** _____ | **Phone #:** _____ **Alternate Phone #:** _____ |
| **Email Address:** _____ | **Email Address:** _____ |

**Housing Status Is:**
☐ Permanent
☐ Temporary
☐ Public
☐ Homeless

**If Homeless:**
☐ Shelter
☐ Transitional
☐ Street
☐ Doubling Up
☐ Other: _____

**Race:**
☐ American Indian/Alaskan Native
☐ Asian
☐ Black/African American
☐ Native Hawaiian
☐ Other Pacific Islander
☐ White
☐ Decline to Specify

**Ethnicity:** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline to Specify

**Hispanic Subgroup:**
☐ Mexican
☐ Mexican American
☐ Chicano/a
☐ Puerto Rican
☐ Cuban
☐ Other
☐ N/A

**Asian Subgroup:**
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other
☐ N/A

**Pacific Islander Subgroup:**
☐ Guamanian or Chamorro
☐ Native Hawaiian
☐ Samoan
☐ Other
☐ N/A

**Does your child have insurance?** ☐ Yes ☐ No **Primary Insured:** ☐ Parent ☐ Legal Guardian ☐ Child

| | |
|---|---|
| **Primary Insurance:** _____ | **Secondary Insurance:** _____ |
| **Group #:** _____ **Policy #:** _____ | **Group #:** _____ **Policy #:** _____ |
| **Insurance Type (e.g., HMO, PPO):** _____ | **Insurance Type (e.g., HMO, PPO):** _____ |
| **Phone #:** _____ | **Phone #:** _____ |
| **Claim Office Address:** _____ | **Claim Office Address:** _____ |

| | |
|---|---|
| **Emergency Contact:** _____ | **Secondary Emergency Contact:** _____ |
| **Phone #:** _____ **Alternate Phone #:** _____ | **Phone #:** _____ **Alternate Phone #:** _____ |
| **Relationship to Child:** _____ | **Relationship to Child:** _____ |

I AUTHORIZE FAMILY AND MEDICAL COUNSELING SERVICE, INC. TO RELEASE ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS CLAIMS FOR ANY SERVICES MY CHILD RECEIVES. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS, FOR ANY SERVICES I RECEIVE, TO FAMILY AND MEDICAL COUNSELING SERVICE, INC.

**Parent/Guardian Signature:** _____ **Date:** ___/___/___ **Staff Signature:** _____ **Date:** ___/___/___

**Thank you for completing our registration form. As we strive to improve the quality of our service to you, we may ask you to update this information at other times during the year.**

Please present ID, insurance card(s), and proof of income. | **Staff verified:** ☐ ID ☐ Insurance Card(s) ☐ Income