



# PEDIATRICS REGISTRATION FORM

(Older Than 12 Years Old)

☐ New ☐ Renewal ☐ Address Change

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Email: \_\_\_\_\_

Child's Name: \_\_\_\_\_ MI: \_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Birth Gender: ☐ Male ☐ Female SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

<b>Gender Identity</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female (Male-to-Female) <input type="checkbox"/> Transgender Male (Female-to-Male) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Choose not to disclose
<b>Sexual Orientation</b>	<input type="checkbox"/> Straight (Not Lesbian or Gay) <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Something Else: _____ <input type="checkbox"/> Choose not to disclose

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

Special Communication Need? ☐ Hearing Aids ☐ Visual Aids ☐ Sign Language ☐ Cognitive or Attentive Concerns ☐ N/A

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Ward: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ MI: \_\_\_\_\_ Second Parent/Guardian Name: \_\_\_\_\_ MI: \_\_\_\_\_

Phone #: \_\_\_\_\_ Alternate Phone #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Alternate Phone #: \_\_\_\_\_

Email: \_\_\_\_\_ Email: \_\_\_\_\_

<b>Housing Status Is:</b> <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary <input type="checkbox"/> Public <input type="checkbox"/> Homeless	<b>Race:</b> <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Decline to Specify	<b>Ethnicity:</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Decline to Specify			
<b>If Homeless:</b> <input type="checkbox"/> Shelter <input type="checkbox"/> Transitional <input type="checkbox"/> Street <input type="checkbox"/> Doubling Up <input type="checkbox"/> Other: _____		<table border="1"><tr><td><b>Hispanic Subgroup:</b> <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other <input type="checkbox"/> N/A</td><td><b>Asian Subgroup:</b> <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other <input type="checkbox"/> N/A</td><td><b>Pacific Islander Subgroup:</b> <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other <input type="checkbox"/> N/A</td></tr></table>	<b>Hispanic Subgroup:</b> <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other <input type="checkbox"/> N/A	<b>Asian Subgroup:</b> <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other <input type="checkbox"/> N/A	<b>Pacific Islander Subgroup:</b> <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other <input type="checkbox"/> N/A
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United States Citizen? ☐ Yes ☐ No

Patient/Parent/Guardian Employee Status: ☐ FT ☐ PT ☐ Unemployed ☐ Other: \_\_\_\_\_

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

<b>Primary Insurance:</b> _____ <b>Group #:</b> _____ <b>Policy #:</b> _____ <b>Phone #:</b> _____	<b>Primary Emergency Contact:</b> _____ <b>Phone #:</b> _____ <b>Relation to Child:</b> _____ <b>Can Agency/Staff's Role be identified to contact?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Secondary Insurance:</b> _____ <b>Group #:</b> _____ <b>Policy #:</b> _____ <b>Phone #:</b> _____	<b>Secondary Emergency Contact:</b> _____ <b>Phone #:</b> _____ <b>Relation to Child:</b> _____ <b>Can Agency/Staff's Role be identified to contact?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

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