BEAR CREEK PEDIATRICS

NEW PATIENT REGISTRATION

Patient Information

Full Name: _____ Date of Birth: _____Gender: ☐ Female ☐ Male

Mailing Address: _____ City/State/Zip: _____

If your child is 13 years or older, please include the following:

Patient Phone Number: _____ Patient Email Address: _____

Parent/Guardian Information

Parent/Guardian 1 Relationship to Patient: ☐ Mother ☐ Father ☐ Other: _____

Full Name: _____ Date of Birth: _____

Mailing Address: _____ City/State/Zip: _____

Cell Phone: _____ Home Phone: _____ Email Address:_____

Does Patient live with you? ☐ Yes ☐ No Employer Name & Phone Number: _____

Parent/Guardian 2 Relationship to Patient: ☐ Mother ☐ Father ☐ Other: _____

Full Name: _____ Date of Birth: _____

Mailing Address: _____ City/State/Zip: _____

Cell Phone: _____ Home Phone: _____ Email Address:_____

Does Patient live with you? ☐ Yes ☐ No Employer Name & Phone Number: _____

Alternate Contact Information (Permission to Treat)

Alternate Contact 1 Relationship to Patient: ☐ Step-Mother ☐ Step-Father ☐ Other: _____

Full Name: _____ Cell Phone: _____

Alternate Contact 2 Relationship to Patient: ☐ Step-Mother ☐ Step-Father ☐ Other: _____

Full Name: _____ Cell Phone: _____

Insurance Information

Primary Insurance Insured By: ☐ Parent 1 ☐ Parent 2 Social Security # of Insured Parent: _____

Insurance Company Name: _____ Insurance ID #: _____ Group #: _____

Secondary Insurance Insured By: ☐ Parent 1 ☐ Parent 2 Social Security # of Insured Parent: _____

Insurance Company Name: _____ Insurance ID #: _____ Group #: _____