Pearland Pediatrics & Sports Medicine

Today's Date:___/___/____

FAMILY REGISTRATION FORM

CHILD'S NAME (First, Middle, Last)	SEX (circle)		DATE OF BIRTH	ETHNICITY (check box)	RACE	PREFERRED DOCTOR (check box)
	M	F		☐Hispanic or Latino ☐Not Hispanic or Latino ☐Prefer not to answer		☐CHAN ☐GANT ☐GRAY ☐DECKER ☐ONHAIZER ☐STROOPE ☐WAGNER
	M	F		☐Hispanic or Latino ☐Not Hispanic or Latino ☐Prefer not to answer		☐CHAN ☐GANT ☐GRAY ☐DECKER ☐ONHAIZER ☐STROOPE ☐WAGNER
	M	F		☐Hispanic or Latino ☐Not Hispanic or Latino ☐Prefer not to answer		☐CHAN ☐GANT ☐GRAY ☐DECKER ☐ONHAIZER ☐STROOPE ☐WAGNER
	M	F		☐Hispanic or Latino ☐Not Hispanic or Latino ☐Prefer not to answer		☐CHAN ☐GANT ☐GRAY ☐DECKER ☐ONHAIZER ☐STROOPE ☐WAGNER
	M	F		☐Hispanic or Latino ☐Not Hispanic or Latino ☐Prefer not to answer		☐CHAN ☐GANT ☐GRAY ☐DECKER ☐ONHAIZER ☐STROOPE ☐WAGNER
	M	F		☐Hispanic or Latino ☐Not Hispanic or Latino ☐Prefer not to answer		☐CHAN ☐GANT ☐GRAY ☐DECKER ☐ONHAIZER ☐STROOPE ☐WAGNER

	PARENT/GUARDIAN #1	PARENT/GUARDIAN #2
Name:		
Relationship to Patient(s):		
Date of Birth:		
Social Security #:		
Home Address:		
Home #:		
Cell #:		
Work #:		
Email Address:		
Employer:		
Occupation:		
Preferred Language:		

Parents are: ☐Married ☐Living Together ☐Separated ☐Divorced If divorced, who is the Custodial Parent? ☐#1 or ☐#2

PLEASE COMPLETE THE BACK OF THIS FORM

PATIENT CONFIDENTIAL COMMUNICATION PREFERENCE

Is it okay to leave a voicemail regarding labs/medical information: ☐Yes ☐No

If yes, who is the preferred contact?_____ Preferred Phone #:_____

Pearland Pediatrics will provide appointment reminders and contact you to keep you informed of any new services or upcoming events. Who is the preferred contact person? ☐Parent #1 ☐Parent #2

How would you wish to be contacted?☐Mailing Address ☐Cell Phone ☐Work Phone ☐Home Phone

☒Email ☐Text Message ***(To receive text messages you must opt in by texting PEAR to 622622)***

At times you may not be able to bring your child in for treatment. Please specify any other adult 18 years or older that is able to act on your behalf in authorizing medical treatment: (i.e., grandparent, aunt, uncle, etc.).
Please check next to the person that you want as the emergency contact in case we are not able to get a hold of either parent/guardian.

NAME	ADDRESS	PHONE #	RELATIONSHIP	EMERGENCY CONTACT?
				☐YES ☐NO
				☐YES ☐NO

MEDICAL INSURANCE INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company:		
Carrier Phone #:		
Policy #:		
Group #:		
Policy Holder:		
Social Security #:		
Date of Birth:		
Relation to Child:		
Phone #:		
Address:		

Do you have Medicaid Insurance? ☐No ☐Yes If yes, please complete the table below for any child on a Medicaid Plan.

CHILD'S NAME	MEDICAID PLAN	ID #