PEARLAND PEDIATRICS & SPORTS MEDICINE

Today's Date:________________

FAMILY REGISTRATION FORM

CHILD'S NAME (First, Middle, Last)	SEX		DATE OF BIRTH	PREFERRED DOCTOR (check box)
	Male	Female		
	○	○		☐ONHAIZER ☐GRAY ☐DECKER ☐MASSANELLI ☐PALACIOS ☐STROOPE ☐HUMMEL ☐HUYNH
	○	○		☐ONHAIZER ☐GRAY ☐DECKER ☐MASSANELLI ☐PALACIOS ☐STROOPE ☐HUMMEL ☐HUYNH
	○	○		☐ONHAIZER ☐GRAY ☐DECKER ☐MASSANELLI ☐PALACIOS ☐STROOPE ☐HUMMEL ☐HUYNH
	○	○		☐ONHAIZER ☐GRAY ☐DECKER ☐MASSANELLI ☐PALACIOS ☐STROOPE ☐HUMMEL ☐HUYNH
	○	○		☐ONHAIZER ☐GRAY ☐DECKER ☐MASSANELLI ☐PALACIOS ☐STROOPE ☐HUMMEL ☐HUYNH
	○	○		ONHAIZER ☐GRAY ☐DECKER ☐MASSANELLI PALACIOS ☐STROOPE ☐HUMMEL ☐HUYNH

Please Circle which applies:	#1 PARENT/STEP PARENT/GUARDIAN	#2 PARENT/STEP PARENT/GUARDIAN
Name:		
Relationship to Patient(s):		
Date of Birth:		
Social Security #:		
Home Address:	______________________________ City: __________State:____Zip Code:_________	______________________________ City: __________State:____Zip Code:_______
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
***If there are legal documents regarding who can obtain care for the child or medical information (Provide a copy of documents).**

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

We text appointment reminders. If you prefer to opt out please indicate your preferred method:
☐Mailing Address ☐Cell Phone ☐Work Phone ☐Home Phone ☐Email

AGREEMENT TO RELEASE PATIENT INFORMATION

We do not discuss any aspect of your child's care with anyone else unless you specifically ask that we do. We understand that many people involve family and close friends in their health care decisions and would like their physician to share information with those close to them. To allow others to be involved in your child's healthcare decisions requires legal authority through a caregiver signed consent. For those that cannot provide consent, we would need a legally valid custodial care or power of attorney documentation, or an adjudicated guardianship arrangement.

NAME (PERSON AUTHORIZED TO ACCESS RECORDS) PHONE RELATIONSHIP TO PATIENT

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EMERGENCY CONTACT

- 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

Please circle which applies:	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company:		
Carrier Phone #:		
Policy #:		
Group #:		
Policy Holder:		
Social Security #:		
Date of Birth:		
Relation to Child:		
Policy Holder Phone #:		
Policy Holder Address:		
Do you participate in an HSA?		

MEDICAID INSURANCE

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 #	MEDICAID PCP