HALIFAX HEALTH

PEDIATRIC PATIENT REGISTRATION

Today's Date:______________________________

Child's Name:______________________________

Child's DOB:____________ Gender:__________ Age:__________ Race:______________

Child's Social Security Number:______________________ Religion:______________________

Patient Lives with: ❑ Mother ❑ Father ❑ Both ❑ Guardian ❑ Other

Child's Home Address:______________________________

City/State/Zip:______________________________

Primary Phone:____________ Secondary phone:____________ Work phone:____________

Email Address for appointment reminders:____________________@____________________

Child's School:______________________________Grade: __________

Mother's Name:______________________________ DOB:__________

Mother s Social Security Number:______________________________

Mother's Address:______________________________

City/State/Zip: ______________________________

Mother s Best Phone Number:______________________________

Father s Name:______________________________ DOB:__________

Father s Social Security Number:______________________________

Father's Address:______________________________

City/State/Zip: ______________________________

Father's Best Phone Number:______________________________

Guardian's Name (if not parent):______________________________ DOB:__________

Guardian's Social Security Number:______________________________

Guardian's Address:______________________________

City/State/Zip: ______________________________

Guardian's Best Phone Number:______________________________

INSURANCE INFORMATION

Insurance Company:______________________________

Policy Number for Child:____________________ Group Number:____________________

Policy Holder Name:______________________________ DOB:__________

Policy Holder Relationship to Patient:____________________ Employer Group:__________

EMERGENCY CONTACT INFORMATION

Name:______________________________ Phone:__________

Address:______________________________

City/State/Zip:____________________ Relationship to Child:____________________