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## Pediatric Patient Registration Form

Today's Date _____

Patient's Name: _____ Date of Birth:_____
(Last) (First) (MI)

Race: (circle one) Asian Black/African American Caucasian Chinese Hispanic Japanese American Indian or Alaska Native Latino Multiracial Pacific Islander Other

Ethnicity: (circle one) Hispanic Non-Hispanic Other

Language: (circle one) English French German Hindi Mandarin Spanish Vietnamese

Street Address:_____ Sex: M F
City:_____ State: _____ Zip Code:_____

Mailing Address:(if different from street address)_____
City:_____ State:_____ Zip Code:_____

Home Phone: _____ Patient's Cell:_____

E-MAIL: _____

Guardian's Name:_____ Relationship to Child:_____
Work/Cell Phone:_____

PERSON RESPONSIBLE FOR BILL: (Must be parent/guardian; or if 18 or older, would be self)
Name:_____
Address: (if different from above)_____
City:_____State:_____Zip Code_____
Phone:_____

INSURANCE INFORMATION: (patients are required to show insurance card at visits.)
Primary Insurance Co.:_____ ID/Group_____ Co-pay$_____
Secondary Insurance Co.:_____ ID/Group_____
Subscriber's Name:_____ Date of Birth:_____
Address: (if different from above)_____

THIS CHILD IS ELIGIBLE FOR THE FEDERAL VACCINES FOR CHILDREN PROGRAM (VFC):Check only one:

___ is enrolled in Medicaid (Includes Mass Health & HMO's, Etc. if enrolled in Medicaid)

___ does not have health insurance (check this box if enrolled in Children's Medical Security Plan)

___ is American Indian (Native American) or Alaska Native

THIS CHILD IS NOT ELIGIBLE FOR THE FEDERAL VACCINES FOR CHILDREN PROGRAM (VFC):

___ has health insurance and is not American Indian (Native American) or Alaska Native

revised 2/1/2015