Uptown Pediatrics Patient Registration

Patient(s) First Name: _____ Last Name: _____ DOB _____

Siblings: Name _____/DOB _____ Name_____/DOB_____

Specialist PT Primary Care Doctor /Name: _____ Phone: _____ _____

Hospital Patient(s) Born In _____ ( ) Male ( ) Female ( ) Other _____

Parent # 1 _____ DOB: _____Phone#_____

Parent # 2 _____ DOB: _____Phone#
Secondary #

Patient's Home Address _____Apt____City____State____Zip_____
Patient lives with: ( ) Both Parents ( ) Parent 1 ( ) Parent 2 ( ) Other_____

Portal Email Address: _____ ( ) Parent 1 ( ) Parent 2 ( ) Patient
(By providing my email, I give consent to receive email updates from Uptown Pediatrics)

Emergency Contact (other than parents): _____ # _____Relationship to patient
_____

Name and # of your preferred pharmacy: _____

Provide insurance card(s) to the Receptionist. Refer to our Financial Policy for additional billing/payment policies

Primary Health Plan: _____ Policy # _____ Group # _____

Primary Policy Holder Name: _____ DOB: _____

Relationship to Patient: _____ Employer_____

Is the patient covered by an additional health plan? ___NO ___YES (list below)

Other Health Plan: _____ Policy #_____ Group # _____

Primary Policy Holder Name: _____ DOB: _____

Relationship to Patient: _____ Employer_____

I certify that the information above is complete and correct

_____ _____ _____

Print Name **Signature** **Date**

_Revised 2.10.2021: Rema