South Charleston Pediatrics

Patient Registration Information

(*Please print and complete all sections before leaving)*

Patient's Information **Sex:** **Male** **Female**

Name: _____ _____ _____
Last First Middle

Birth Date : _____/ _____/ _____

Physical Street Address: _____ **Apt.**_____

City: _____ **State:** _____ **Zip Code:** _____

Mailing Address : **Same as above**

_____ **Home Phone:** _____

City: _____ **State:** _____ **Zip Code:** _____ **Cell Phone:** _____

Parent or Guardian Name: **1.** _____ **2.** _____
& Relationship

Patient Responsible Party Information

Responsible Party Information

_____ _____ _____
Last First Middle

Birth Date: _____/ _____/ _____ **Social Security #** _____-_____-_____

Street Address: _____ **Apt.**_____

City: _____ **State:** _____ **Zip Code** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email address: _____
Do you wish to receive E-Mails concerning Health Information? **YES** **NO**

Patient's Insurance Information

Responsible Party (Please list the person who has the coverage with the insurance company)

_____ _____ _____
Last First Middle

Relationship to patient: _____

Birth Date: _____/ _____/ _____ **Social Security #** _____-_____-_____

Occupation: _____ **Employer:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Primary Insurance: _____

Secondary Insurance: _____