

## RIVERSIDE PEDIATRICS REGISTRATION FORM

**Please Print**

Child's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_ Other: \_\_\_\_\_

Sibling 1: Name \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: Male/Female/Other

Sibling 2: Name \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: Male/Female/Other

Sibling 3: Name \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: Male/Female/Other

Address: Street \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Custodial Parent #1 Name: Last \_\_\_\_\_ First: \_\_\_\_\_ DOB: \_\_\_\_\_

Contact info: Cell \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary email address, for office communications: \_\_\_\_\_

Custodial Parent #2 Name: Last \_\_\_\_\_ First: \_\_\_\_\_ DOB: \_\_\_\_\_

Contact info: Cell \_\_\_\_\_ Relationship: \_\_\_\_\_

Email address: \_\_\_\_\_

Emergency Contact. **Other than parents:** Name \_\_\_\_\_

Relationship: \_\_\_\_\_ Cell: \_\_\_\_\_

Pharmacy info: Name \_\_\_\_\_ Street Address: \_\_\_\_\_

Town: \_\_\_\_\_ State: \_\_\_\_\_

Health Insurance carried by **Parent/Guardian:** Name \_\_\_\_\_ DOB: \_\_\_\_\_

Name of Plan: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Who can we thank for your referral? \_\_\_\_\_

**Please sign below:**

1. Signature of custodial parent requesting services: \_\_\_\_\_

2. I have been offered HIPPA privacy notices and a patient's bill of rights: \_\_\_\_\_

3. I consent to the office communicating to me via Text/VM/ and Email: \_\_\_\_\_

Date: \_\_\_\_\_