BRENTWOOD PEDIATRICS
PATIENT REGISTRATION

Child 1: Last Name: _____ First Name: _____ MI: _____

DOB: _____/_____/_____ Primary Language: _____ Sex: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White

MAILING ADDRESS:

Street or PO Box: _____

City: _____ State: _____ Zip Code_____

Primary Phone: (_____) _____ (Home or Cell) Secondary Phone: (_____) _____ (Home or Cell)

INSURANCE:

Primary Policy: Insurance carrier: _____

Subscriber and their DOB: _____

Secondary Policy: Insurance carrier: _____

Subscriber and their DOB: _____

Marital Status of Parents (circle ONE): Married Separated Divorced Widowed Single

MOTHER/GUARDIAN:

Name: _____

DOB: _____ Lives with patient? Yes or No

Primary phone: (_____) _____

Home email: _____

Employer: _____

Occupation: _____

FATHER/GUARDIAN

Name: _____

DOB: _____ Lives with patient? Yes or No

Primary phone: (_____) _____

Home email: _____

Employer: _____

Occupation: _____

SIBLING NAMES, DOB AND GENDER:

_____ _____

_____ _____

HOW WOULD YOU PREFER TO BE CONTACTED REGARDING (CIRCLE ONE):

Appointment Reminders and Recall Notices: Text Message / Home email

PRIMARY PHYSICIAN: (Circle one): DR. ADAMS DR. BIRMINGHAM DR. SMITH

Brentwood Pediatrics