Milestones Pediatric

Patient Registration Form

Patient Information

Patient Name: (Last, First) _____ Date of Birth _____

Sex : M / F ____ Age _____ Patient resides with _____

Address: _____

City _____ State _____ Zip code _____

Home Phone#_____ Emergency Contact _____

Emergency Contact Phone # _____

Parent or Legal Guardian Information

Mother/ Guardian Name (Last, First) _____

Guardian relation to patient _____

Date of Birth _____ Phone _____ SSN _____

Adress: _____City _____

State _____ Zip code _____

Home Phone/ Cell Phone _____ Work Phone _____

Email: _____Employer _____

Father/ Guardian Name (Last, First) _____

Guardian relation to patient _____

Date of Birth _____ Phone _____ SSN _____

If address is same as above check here ☐

Adress: _____City _____

State _____ Zip code _____

Home Phone/ Cell Phone _____ Work Phone _____

Email: _____Employer _____

Insurance Information (Primary Insurance)

Insurance Company Name _____

Policy Holder's name _____ Policy Holder's Date of Birth _____

Relationship to Patient _____ Plan Type _____ (HMO, PPO)

Employer Name or Self-Insured _____

Insurance ID # _____ Group # _____

Insurance Phone # _____

Insurance Information (Secondary Insurance)

Insurance Company Name _____

Policy Holder's name _____ Policy Holder's Date of Birth _____

Relationship to Patient _____ Plan Type _____ (HMO, PPO)

Employer Name or Self-Insured _____

Insurance ID # _____ Group # _____

Insurance Phone # _____

Preferred Pharmacy Information

Name: _____

Address: _____

Phone # _____

How did you hear about us

Family / Friend ☐ Insurance ☐ Internet/Website ☐ Other ☐

☐ By Checking this box, you agree to receive recurring Messages from Milestones Pediatric, please reply STOP to opt out. Reply Help for help. Message frequency varies. Message and data rates may apply.

_____ _____

Signature of Parent/ Guardian Date