Aquarius Pediatrics
Growing Happy Families

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# Patient Registration Form

Date: _____

Patient Full Name & DOB : _____

Race: _____ Nickname:_____Age: _____

Street address, include City, State & Zip:

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Home Phone number: _____

Preferred Language, circle one: English Spanish

How did you find us, circle one:
Insurance Plan Google Referred by: _____
Family Friend Close to home Other:_____

Siblings (names and birthdates): #1_____
#2_____
#3_____

People who can bring child to appointment:
_____
_____

Pharmacy Information:
Name:_____ Phone number :_____
Address: _____

Insurance Information

Is this patient covered by insurance? (circle one) YES NO (Self Pay)
Name of primary Insurance _____ Responsible Party:_____
Member ID# _____ GROUP #: _____
Insurance contact information: _____
Responsible Party's name & DOB: _____ Address: _____
Responsible party's Occupation & Employer: _____
Patients relationship to subscriber: _____

Is there a secondary insurance, circle one: YES (see page 2) NO

Name of secondary Insurance _____ Responsible Party:_____
Member ID# _____ Group #: _____
Insurance contact information: _____
Responsible Party's name & DOB: _____ Address: _____
Responsible party's Occupation & Employer: _____

Family/Contact Information:

Patient resides primarily with, circle one: Both parents Mother Father
Other: _____ Legal Guardian: _____

Parents are? circle one: Married Divorced Separated other:_____

Mother's name & DOB: _____

Contact Information: Home _____ Work _____
Cell _____ Email _____
Occupation & employer: _____

Best way to reach me, circle one: Home number Work number Cell Email

Father's name & DOB: _____

Contact Information: Home _____ Work _____
Cell _____ Email _____
Occupation & employer: _____

Best way to reach me, circle one: Home number Work number Cell Email

The above information is true and to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Aquarius Pediatrics or insurance company to release any information required to process my claims.

I give permission for Aquarius Pediatrics to contact me via email and/or text message.

Parent/Guardian name: _____

Parent/ Guardian Signature: _____

Today's Date: _____