REIS PEDIATRICS
KAILUA PROFESSIONAL CENTER I | 30 AULIKE ST, SUITE 500, KAILUA, HI 96734 | 808.263.8822
WWW.REISPEDIATRICS.COM

PATIENT REGISTRATION FORM

TODAY'S DATE: / /

LIST ALL CHILDREN:

Patient's name (last, first middle) | Nickname | Sex (M of F) | Date of Birth

Preferred email AND Preferred Cell phone number (for appointment reminders and contacting)

PARENT (OR LEGAL GUARDIAN) INFORMATION

Mother's name (last, first middle) | Date of birth

Address | City | State | Zip

Additional phone # ☐ Cell ☐ Home ☐ Work

Father's name (last, first middle) | Date of birth

Address (if different from above) | City | State | Zip

Additional phone # ☐ Cell ☐ Home ☐ Work

BILLING ADDRESS (IF DIFFERENT FROM ABOVE)

☐ Guardian ☐ Other

Attention to (name or industry) | Relationship to patient

Address | City | State | Zip | Phone number

EMERGENCY CONTACT INFORMATION

Name of local friend or relative | Relationship to patient | Emergency contact # | Alternate contact #

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Patient's name (Last, first middle) LIST ALL CHILDREN: _____

_____

INSURANCE INFORMATION: Is this patient covered by insurance? ☐ No, I will pay for visit ☐ Yes (please give us a copy of card)

1. PRIMARY INSURANCE: ☐ HMSA ☐ QUEST-HMSA ☐ Tricare ☐ Other:

Subscriber ID # (Social security number if TRICARE)	Coverage code	Group	Effective date
	☐ Self ☐ Child	☐ M ☐ F	
Subscriber name	Patient's relationship to subscriber	Sex	Date of Birth

2. SECONDARY INSURANCE: ☐ HMSA ☐ QUEST-HMSA ☐ Tricare ☐ Other:

Subscriber ID # (Social security number if TRICARE)	Coverage code	Group	Effective date
	☐ Self ☐ Child	☐ M ☐ F	
Subscriber name	Patient's relationship to subscriber	Sex	Date of Birth

I certify that the above information is accurate and current to the best of my knowledge. By providing my cell phone number and/or email address, I consent to Reis Pediatrics contacting me regarding my child's medical care via cell phone, text or email.

Credit Card Payment Authorization: ☐ Visa ☐ Mastercard ☐ Prefer not to provide (Required for hospital newborns and visitors)

Name on Credit Card	Card Number	Exp. Date	Security Code

Billing Address

By signing below, you are agreeing to and understand the above financial agreement and that you understand, as the parent and/or guarantor of the minor child described above as being the patient, that you are responsible for any charges incurred and agree to pay them as required within 30 days of receiving your billing statement.

Print Name (parent or legal guardian)	**Signature**	**Date**