Little Oaks Pediatrics
Patient Registration

Patient/Sibling Information

Child's (Legal) Name: First Name – MI – Last Name	**Race**	**Ethnicity**	**Birth Date**	**Sex**	**Soc. Sec #**
	Black White Hispanic Asian Native American	Non Hispanic/Latino Hispanic/Latino		M F	
	Black White Hispanic Asian Native American	Non Hispanic/Latino Hispanic/Latino		M F	
	Black White Hispanic Asian Native American	Non Hispanic/Latino Hispanic/Latino		M F	
	Black White Hispanic Asian Native American	Non Hispanic/Latino Hispanic/Latino		M F	
	Black White Hispanic Asian Native American	Non Hispanic/Latino Hispanic/Latino		M F	

Home Address	City	State	Zip

Home Phone Number	Cell Number	**Preferred Language:** English Spanish Other:

Mother (Circle One) Birth / Stepmother / Adoptive Mother / Foster Any custody Concerns? Y / N

Full Name (First MI Last)	Social Security #	Date of Birth

Home Address if different from Patient	City	State	Zip Code

Home Phone Number / Cell Phone Number	E-Mail Address

Occupation / Employer	Business Phone Number

Preferred telephone contact is: (Circle One) Home / Cell / Business	May we leave a confidential message at this number? Y / N

Father (Circle One) Birth / Stepfather / Adoptive Father / Foster Any custody Concerns? Y / N

Full Name (First MI Last)	Social Security #	Date of Birth

Home Address if different from Patient	City	State	Zip Code

Home Phone Number / Cell Phone Number	E-Mail Address

Occupation / Employer	Business Phone Number

Preferred telephone contact is: (Circle One) Home / Cell / Business	May we leave a confidential message at this number? Y / N

Emergency Contact / Additional Persons

Please list all Emergency Contacts/Persons who may have permission to bring the patient in for medical care and sign consent for any vaccine administration.

Name	Authorized to bring Child to Office? Yes No	Phone Number	Relationship to Child
	Yes No		

Insurance Information

Primary Insurance Company Name	Employer

Telephone #	Co-pay Amount

ID#	Group #

Full Name of Insured	Insured Date of Birth

Insured Social Security #	Relationship to Patient

Do you have Secondary Insurance? Yes No	If Yes, Insured Name	DOB

Ins Co Name	ID#	Grp#

I hereby authorize the physician to furnish information to insurance concerning this illness/accident and hereby irrevocably assign to the doctor all payments for medical service rendered. In the event my account is placed in the hands of an attorney for collection, I agree to pay all cost and expenses including all attorney fees related to the collection thereof. I understand that I am financially responsible for all charges whether or not covered by insurance. I also acknowledge receipt of the Little Oaks Pediatrics PLLC financial policy. A copy of this authorization shall be considered as the original.

Signed _____ Date _____