Patient Registration Form

Pediartic Specialty Care of Macon, P.C.

	PATIENT	Mother	Father
Last Name			
First Name, Middle			
Address, Apt #			
City, State, Zip			
Home Phone			
Mobile Phone			
Email Address			
Employer / School			
Work Phone			
Work Address			
Date of Birth			
Gender	Male / Female		
Race Ethnicity (circle one)	Native American, African American, Hispanic, Asian American White, Decline to answer		
Siblings		M/F	DOB / /
Siblings		M/F	DOB / /
Siblings		M/F	DOB / /

	Other Contact		PREFERRED PHARMACY
Name		**Name**	
Home Phone		**Address**	
Mobile Phone			
Relationship			

PRIMARY INSURANCE		***Complete if Card not Present***	
Complete if Card Present		Insurance Company Name	
Insurance Company Name		InsuranceCopay:	
Policy Owner Name		Policy / ID #	
Policy Owner Date of Birth		Group / Employer #	
Relationship to Patient		Claims Mailing Address	
Effective Date (mm/dd/yy):		City, State, Zip	
SECONDARY INSURANCE		Policy Owner Name	
Insurance Company Name		Policy Owner Date of Birth	
Policy Number		Relationship to Patient	
Group Number		Effective Date (mm/dd/yy)	