NEW PATIENT REGISTRATION FORM

GATEWAY PEDIATRICS

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PATIENT INFORMATION **DATE**: ________________

PATIENT____**SEX** _____**M**____**F**
(Last) (First) (Middle Initial)

DATE OF BIRTH ________**AGE**_____**SOCIAL SECURITY#**____________

Mother/Guardian: Name:____

Date of Birth:_______________________**SS #**_________________

Address____

City/State/Zip____

Home Phone___________________________**Cell Phone**_____________________________

Employer________________________________**Occupation**__________________________

Work Phone:________________________________

Father/Guardian: Name:____

Date of Birth:_________________________**SS #**_________________

Address____

City/State/Zip____

Home Phone ______________________________**Cell Phone**__________________________

Employer________________________________**Occupation**__________________________

Work Phone:______________________________

Sibling_______________________________________**Sex**___**M**___**F** **Date of Birth**_______________

Sibling_______________________________________**Sex**___**M**___**F** **Date of Birth**_______________

Sibling_______________________________________**Sex**___**M**___**F** **Date of Birth**_______________

Children live with: Mother Father Both Guardian/Other (please explain) ______________________

Whom can we thank for this referral? ____

EMERGENCY INFORMATION – (Person to contact directly if we are unable to reach you)

PLEASE LIST THE NAME OF A PERSON *NOT* LIVING WITH YOU

Name______________________________________**Relationship**________________________________

Home Phone _____________**Work Phone**________________**Cell Phone**_______________________

GATEWAY PEDIATRICS
INSURANCE CARRIER INFORMATION

Party responsible for payment of medical services: Father Mother Both Other

Who is responsible for these services if NOT parent? ____________________________

Name____

Date of Birth _____________**Age** ________**Sex** ____ **SS #**__________________

Address____

City/State/Zip:____

Home Phone ______________________________ **Cell Phone:**____________________________

Relationship to Patient _____________________ **Employer**______________________________

Work Address____

Work Phone______________________________

PRIMARY INSURANCE COMPANY____

Name of Policy Holder____

ID Number (*Usually SS#)*__________________________**Group Number**____________________

Co-payment, Coinsurance Amount or Deductible:_____________________________

Billing Address (Ins. Co)____

City/State/Zip:____

Phone:_____________________________________

SECONDARY INSURANCE COMPANY____

Name of Policy Holder____

ID Number (*Usually SS#)*_____________________________**Group Number**_________________

Copayment, Coinsurance Amount or Deductible:_____________________________

Billing Address (Ins. Co)____

City/State/Zip:____

Phone:_____________________________________

Name of Parent or Responsible Party____

Signature of Parent or responsible party_______________________________________

Date:__________________________