BERKS PEDIATRICS PATIENT REGISTRATION FORM

TODAY'S DATE_____

PATIENT NAME_____BIRTHDATE_____

SOCIAL SECURITY NUMBER_____INSURANCE PROVIDER NAME_____

INSURANCE PROVIDER ID#_____GROUP#_____SUBSCRIBER NAME_____

ADDRESS_____

SEX: M OR F **PRIMARY PHONE NUMBER_____PRIMARY LANGUAGE_____**

RACE (*PLEASE CHECK ALL THAT APPLY*) **IS THIS PATIENT CURRENTLY IN FOSTER CARE?** YES OR NO

- WHITE
- BLACK/AFRICAN AMERICAN
- AMERICAN INDIAN/ALASKA NATIVE
- ASIAN
- NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER

ETHNICITY (*PLEASE CHECK ALL THAT APPLY)*

- HISPANIC/LANTINO
- NOT HISPANIC/LATINO

DOES THE PATIENT HAVE ANY ALLERGIES? (*SEASONAL, FOOD, DRUG, ETC.*)_____

IF YES WHAT IS THE ADVERSE REACTION?_____

DOES THE PATIENT USE AN EPI-PEN? YES OR NO

PREFERRED PHARMACY NAME, ADDRESS, AND PHONE_____

_____

PATIENT'S MOTHER'S NAME: FIRST_____LAST_____

MAIDEN LAST NAME_____HOME PHONE_____

ADDRESS IF DIFFERENT FROM PATIENT_____

CELL PHONE_____WORK PHONE_____EXT_____

EMAIL ADDRESS_____DOB_____

PATIENT'S FATHER'S NAME: FIRST_____LAST_____

ADDRESS IF DIFFERENT FROM PATIENT_____

HOME PHONE_____CELL PHONE_____WORK PHONE_____EXT_____

EMAIL ADDRESS_____DOB_____

WHO SHOULD BE CONTACTED FIRST? (*CIRCLE ONE*) MOTHER OR FATHER

IN CASE OF AN EMERGENCY AND WE ARE UNABLE TO REACH NEIGHTER ONE OF THE PARENTS LISTED ABOVE PLEASE LIST AN ALTERNATE CONTACT PERSON:

NAME_____PATIENT RELATION_____

HOME PHONE_____CELL PHONE_____WORK PHONE_____EXT____

PARENT OR GUARDIAN SIGNITURE_____DATE_____