MIDDLETOWN PEDIATRICS PATIENT REGISTRATION FORM

Select your preferred way to receive appointment reminders: ☐ **Email** ☐ **Text Message** ☐ **Voicemail**

CHILD'S FULL LEGAL NAME: (Please Print)	Date of Birth:	Social Security #:	Sex:
CHILD'S PREFERRED NAME:	Preferred Phone #:		
Mailing Address:	City, State, & Zip Code:		
Preferred Email Address:			
RACE: ☐ Asian ☐ Black/African American ☐ White or Caucasian ☐ Other___________________			
ETHNICITY: Hispanic/Latino Non-Hispanic	PRIMARY LANGUAGE: English Spanish Other_______________		

PARENT/LEGAL GUARDIAN(S) INFORMATION

PARENT NAME: (Please Print)	Date of Birth:	Social Security #:	
Mailing Address: (if different from above)	Home #:	Work #:	Cell #:
PARENT'S EMPLOYER:			

PARENT NAME: (Please Print)	Date of Birth:	Social Security #:	
Mailing Address: (if different from above)	Home #:	Work #:	Cell #:
PARENT'S EMPLOYER:			

BILLING GUARANTOR INFORMATION

GUARANTOR NAME:	Date of Birth:
Mailing Address: (if different from above)	City, State, & Zip Code:

PREFERRED PHARMACY

PHARMACY NAME:	TELPHONE #:
PHARMACY ADDRESS:	

FORM COMPLETED BY:

______________________	______________________	______________________
NAME (print)	**Signature**	**Date**