SUGARTOWN PEDIATRICS, LLC
PATIENT REGISTRATION FORM

PRESENT INSURANCE CARD TO RECEPTIONIST BEFORE THE PATIENT IS SEEN

PLEASE PRINT CLEARLY

FAMILY
Name:_____
Address:_____ Apt/Fl/Suite _____
City, State, Zip: _____Home Phone:_____
Cell Phone: _____ E-Mail: _____

CHILDREN

Names	Nicknames	DOB	M/F
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____

PARENT INFO	MOTHER	FATHER
Name	_____	_____
DOB	_____	_____
Address (if different)	_____	_____
City, State, Zip	_____	_____
Home Phone (if different)	_____	_____
Employer	_____	_____
Work Phone	_____	_____

EMERGENCY CONTACT
Name:_____ Relationship to Patient: _____
Address:_____ Home Phone: _____
City, State, Zip:_____ Cell Phone: _____

SIGNIFICANT BIRTH HISTORY
Hospital:_____ Vaginal____ C-Section____ Birth Wt _____
Complications:_____ Wks gestation at birth _____

SIGNIFICANT PAST MEDICAL HISTORY
Allergies _____
Hospitalization/Surgery _____
Current Medications _____

FAMILY HISTORY
Does anyone in your family have any of the following conditions?:

	NO	YES	Relationship To Patient		NO	YES	Relationship To Patient
Alcoholism	____	____	_____	High Blood Press	____	____	_____
Allergies	____	____	_____	Kidney Disease	____	____	_____
Asthma	____	____	_____	Lead Poisoning	____	____	_____
Bleeding Disorders	____	____	_____	Mental Illness	____	____	_____
Cancer	____	____	_____	Mental Retardation	____	____	_____
Diabetes	____	____	_____	Rheumatic Fever	____	____	_____
Drug Abuse	____	____	_____	Seizure Disorder	____	____	_____
Early Infant Death	____	____	_____	Sickle Cell Disease	____	____	_____
G6PD Deficiency	____	____	_____	Tuberculosis	____	____	_____
Heart Disease	____	____	_____	Vision Problems	____	____	_____
Hearing Loss	____	____	_____	Other_____	____	____	_____

PLEASE READ THE FOLLOWING FINANCIAL POLICY CAREFULLY AND SIGN.....