Black & Benton Pediatrics

PATIENT REGISTRATION FORM

Patient Information

Last Name: ___________________________________

First Name: ___________________________________

Middle Name: ________________________________

Prefers to be called:___________________________

DOB:_____________ SS#:_____________________

Sex:_______________ Race:___________________

Street Address: ______________________________

City:_________________ County: ______________

State:_____ Zip: __________ Hispanic: ☐ Yes ☐ No

Home Phone#: _______________________________

Cell Phone#:__________________________________

Emergency Contact

Please list name of a friend or relative that does not live with you and can be contacted in case of an emergency:

Name:_____________________________________

Relationship to patient:________________________

Home Phone #:_____________________________

Cell Phone #:_______________________________

Mother's Information

Last Name:___________________________________

First Name:___________________________ MI:_____

Street Address: _______________________________

City:_______________ State:______ Zip: __________

Home Phone #: _______________________________

Cell Phone #: _________________________________

SS#:____________________ DOB:______________

Marital Status: (check one of the following)

_Single _Married _Divorced _Separated _Widowed

Occupation:___________________________________

Name of Employer: ____________________________

Work Phone #: ________________________________

Father's Information

Last Name:___________________________________

First Name:___________________________ MI:___

Street Address:_______________________________

City:_______________ State:______ Zip:________

Home Phone #:_______________________________

Cell Phone #:_________________________________

SS#:____________________ DOB:______________

Marital Status: (check one of the following)

_Single _Married _Divorced _Separated _Widowed

Occupation:__________________________________

Name of Employer:____________________________

Work Phone #:_______________________________

Insurance Information

Name of Insurance: ____________________________

Name of Policy Holder: _________________________

DOB:_____________ ID#: ______________________

Pharmacy Information

Pharmacy Name:______________________________

Pharmacy Phone #:___________________________

Date Updated:___________