Hendricks Regional Health Medical Group
Pediatric Patient Registration

Please Print Clearly

Date________

Patient Information

Name ______________________________

Address ____________________________

City _______________________________

State ________ Zip Code______________

Home Phone_________________________

Parent Phone Number (cell)____________

Parent Phone Number (work)____________

Date of Birth ___________ Male ☐ Female ☐

Single ☐ Married ☐ SSN________________

Emergency Contact ___________________

(**NOT** living with you)
Emergency Contact phone _____________

Relationship to Emergency Contact ________

Primary Insurance ____________________

Secondary Insurance__________________

Local Pharmacy _______________________
(name and location)

Mail In Pharmacy _____________________

Referred By _________________________

Email address ________________________

.

Physician ________________________

Responsible Party (person who will receive statements)

Name_____________________________

Address ___________________________

City _______________________________

State ________ Zip Code ______________

Parent Information

Mother's Name_______________________

Address ___________________________
(If different from patient)

Father's Name _______________________

Address ___________________________
(If different from patient)

Custodial Parent if Divorced ______________

Insured Information

Primary Ins: Insured Name _______________
Date of Birth _________ SSN ___________
Relationship to patient _________________

Secondary Ins: Insured Name _____________
Date of Birth _________ SSN ___________
Relationship to patient _________________

Additional Information

Race ______________________________

Ethnicity ___________________________
(Options: Hispanic, Non-Hispanic, Refuse to report)

Primary Language _____________________

Patient Printed Name ___________________________ Date of Birth ___________

At Hendricks Regional Health we take the privacy of your health information seriously. We will not release a patient's health information outside of the allowed exceptions spelled out in our Notice of Privacy Practices without your verbal or written permission.

This form gives you the opportunity to tell us who we can speak to regarding your health information. You are not required to list anyone and you can change who we are permitted speak to at any time by completing a new form.

I authorize Hendricks Regional Health Medical Group physicians and/or staff to speak to the individuals listed below regarding my health and billing information. I understand that I can revoke this authorization at any time by completing a new form.

Name	Relationship
1. ____________________________________	_______________________
2. ____________________________________	_______________________
3. ____________________________________	_______________________
4. ____________________________________	_______________________

____ ______________
Signature Date

____
Witness