Pediatric
THE ORTHOPEDIC CENTER

Child/Dependent Registration Form

Account No.	Entered Date
Reg. By	Office Site
☐ New ☐ Change	Info. Change:

Please complete this form in order to ensure proper billing of your services. **Please Print**. Today's Date: _____

Patient Information

Patient Last Name: _____

First Name: _____ MI: _____

Other Name/AKA: _____

Addr1: _____

Addr2: _____

City, State, Zip: _____

Preferred Method of Contact:
☐ Alt Phone Number ☐ Email ☐ Letter
☐ Phone Call (Cell) ☐ Phone Call (Home)

Employment Status:
☐ Employed Full Time ☐ Employed Part Time ☐ Student

Employer: _____

Social Security Number: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Home Phone: (_____) _____

Alt Phone: (_____) _____

Cell Phone: _____

Email Address: _____

Ethnicity: **(Data is used for statistical reporting.)**
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient Declined

Race: **(Data is used for statistical reporting.)**
☐ American Indian or Alaska Native ☐ Black or African American
☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ White
☐ Patient Declined

Language: ☐ English ☐ Spanish ☐ Other _____

Insurance Information

(A separate form is required for worker's compensation, automobile liability, or legal services.)

PRIMARY CARRIER: _____

Address: _____

Subscriber's Name: _____

Subscriber's DOB: _____ Sex: ☐ M ☐ F

Subscriber's Employer: _____

Telephone #: (_____) _____

Child's ID: _____

Group/Plan #: _____ Effective Date: _____

Subscriber SS#: _____ Relationship to Patient: _____

PCP listed on Card: _____

SECONDARY CARRIER: _____

Address: _____

Subscriber's Name: _____

Subscriber's DOB: _____ Sex: ☐ M ☐ F

Subscriber's Employer: _____

Telephone #: (_____) _____

Child's ID: _____

Group/Plan #: _____ Effective Date: _____

Subscriber SS#: _____ Relationship to Patient: _____

PCP listed on Card: _____

Primary Care Phys.: _____

Address: _____

City, St., Zip: _____

Telephone #: (_____) _____

Refer. Phys. (if different): _____

Address: _____

City, St., Zip: _____

Telephone #: (_____) _____

Pharmacy Name, Address & Phone #: _____

Guarantor Information

(Guarantor is the person financially responsible for this patient's bill.)

Guarantor: _____

Addr1: _____

Addr2: _____

City, State, Zip: _____

Employer: _____

Address: _____

City, State, Zip: _____

Driver's License # _____ State _____

Patient's Relationship to Guarantor: _____

Social Security Number: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

Email Address: _____

Other Parent or Guardian

Parent/Guardian: _____

Addr1: _____

Addr2: _____

City, State, Zip: _____

Employer: _____

Address: _____

Work Phone: (_____) _____

Patient's Relationship to Guarantor: _____

Social Security Number: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Home Phone: (_____) _____

Cell Phone: (_____) _____

City, State, Zip: _____

Driver's License # _____ State _____

Emergency Contact Information

(Someone living outside the primary household.)

Last Name, First Name: _____

Addr1: _____

Addr2: _____

City, State, Zip: _____

Patient's Relationship to Contact: _____

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

List All Children/Siblings

Child #1 Last Name	First Name	Date of Birth
Child #2 Last Name	First Name	Date of Birth
Child #3 Last Name	First Name	Date of Birth
Child #4 Last Name	First Name	Date of Birth

How did you hear about our practice? ☐ Word of Mouth (Friend, Family, or Coworker) ☐ Google or Other Online Search

☐ Practice Website ☐ Online Reviews (Google, elp, Healthgrades, etc.) ☐ Social Media (Facebook, Instagram, etc.)

☐ Physician Referral / Emergency Room ☐ Insurance Provider or Health Plan Directory ☐ Ongoing Care / Previous Patient

☐ Community Event or Health Fair ☐ Digital Ad (Online Banner, Sponsored Post, etc.) ☐ Print Ad (Newspaper or Magazine)

☐ Brochure or Flyer ☐ Billboard ☐ Radio ☐ TV ☐ Other: _____