Premier Pediatrics, P.A.
Patient Registration Form

Date _____/_____/_____

Child's name ____

Previous Last Name ______________________ Nickname ______________________

Mailing Address ____________________________________ Zip Code ____________

SS# ______________________ Date of Birth _____/_____/_____ Sex: M __ F __

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Father's Full Name ____

SS# ______________________ Date of Birth _____/_____/_____

Phone ______________________ Cell ______________________

Mailing Address (if different than child's)

____________________________________ Zip Code ____________

Employer ______________________ Phone of employer ______________________

Insurance coverage with employer for child? Yes __ No __

If Yes, Name of Insurance Company ____

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Mother's Full Name ______________________ Maiden Name ______________________

SS# ______________________ Date of Birth _____/_____/_____

Phone ______________________ Cell ______________________

Mailing Address (if different than child's)

____________________________________ Zip Code ____________

Employer ______________________ Phone of employer ______________________

Insurance coverage with employer for child? Yes __ No __

If Yes, Name of Insurance Company ____

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Other Insurance Coverage (Medicaid, NC Health Choice, etc.) ______________________

Emergency Contact #1 ______________________ Relationship ____________ Phone____________

Emergency Contact #2 ______________________ Relationship ____________ Phone____________

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Preferred Method of contact: E-mail ____

Phone____________ Fax ____________ Portal ____________

Preferred Language ______________________ Preferred Pharmacy______________________

Ethnicity: American Indian __ Asian __ African American/Black __ Caucasian __
European __ Hispanic __ Other __

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Consent for Treatment and Payment Methods

Please read this section carefully

I give permission for physicians of Premier Pediatrics, P.A. or person designated by them to interview, examine, and perform necessary laboratory/radiological procedures and to provide appropriate treatment to the above named minor. I give permission for evaluation and treatment granted whether child presented by parent, other family member, unrelated third party, or unaccompanied. I give permission to update all current medications.

Date _____/______/______ Signature ______________________ Relationship ______________________

Changes in above information (i.e. new address, phone, etc.) or explanation (i.e. "parent separation", "child living with grandmother", etc.)

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Return this completed form to the receptionist along with current insurance and medicaid cards. Thank you!
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