

**Mercer Island Pediatrics, Inc. P.S.  
REGISTRATION FORM**

ID# \_\_\_\_\_

Today's Date \_\_\_\_\_

Physician \_\_\_\_\_

**PATIENT INFORMATION**

Patient's last name:		First:	MI	Birth Date:	Sex:	Patient's cell:	
Street Address:			SSN:		Home phone:		
City:				State:		ZIP	
Sibling names/DOB:							

**PARENT INFORMATION**

MOTHER/GUARDIAN				FATHER/GUARDIAN			
Last name:		First:	MI:	Last name:		First:	MI:
Address (if different from patient)				Address (if different from patient)			
Home phone:		Work :	Cell :	Home phone:		Work :	Cell :
Employer:			Occupation:	Employer:			Occupation:
Emp. Address:				Emp. Address:			
Relation to Pt:			DOB:	Relation to Pt:			DOB:
Send bills to this address Yes <input type="checkbox"/> No <input type="checkbox"/>				Send bills to this address Yes <input type="checkbox"/> No <input type="checkbox"/>			

**INSURANCE INFORMATION**

Is this patient covered by insurance? Yes  No  Please give your insurance card to the receptionist.

Primary insurance		Group no.:	Policy no.:	Co-payment:
Subscriber's name:			Subscriber's SSN	DOB
Pt's relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Other				
Secondary insurance:		Group no.:	Policy no.:	Co-payment:
Subscriber's name:			Subscriber's SSN	DOB
Pt's relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Other				

**EMERGENCY CONTACTS**

Name of local friend or relative (not living at same address): \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_

Phones: [H] \_\_\_\_\_ [W] \_\_\_\_\_ [C] \_\_\_\_\_

The above information is true to the best of my knowledge.

Name	Signature	Relationship to Patient	Date
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