MERCER ISLAND PEDIATRICS, INC. P.S.

REGISTRATION FORM

Last Name_____ First Name_____ Middle_____

Date of Birth_____ **Sex** ■ M □ F **Gender Identity** _____ **Orientation** _____

SSN_____ Phone_____

Address_____ City_____ State____ Zip_____

Race: ☐ Caucasian ☐ African/Amer. ☐ Native Amer/Alaskan ☐ Pac. Islander ☒ Other_____

Ethnicity: ☒ Non-Hispanic ☐ Hispanic **Preferred Language:** ☒ English ☐ Other: _____

Preferred Method of Contact: ☒ Email ☐ Text ☐ Call

Please list all Children in the Family

Name: DOB:

Name: DOB:

Name: DOB:

PARENT INFORMATION					
PARENT #1			PARENT #2		
Last Name:	First Name:	DOB:	Last Name:	First Name:	DOB:
Address (If different from patient): Send bills to this address? ☐ Yes ☒ No			Address (If different from patient): Send bills to this address? ☐ Yes ☒ No		
Home Phone:	Work Phone:	Cell Phone:	Home Phone:	Work Phone:	Cell Phone:
Employer:	Occupation:		Employer:	Occupation:	
Email Address:			Email Address:		
Relationship to Patient:			Relationship to Patient:		
HOW DID YOU HEAR ABOUT MERCER ISLAND PEDIATRICS? **EMAIL ADDRESS FOR PATIENT PORTAL:**					

INSURANCE INFORMATION			
Primary:	Group #:	Policy #:	Co-Payment:
Subscriber:	Subscriber SSN:	Subscriber DOB	Patient Relationship to Subscriber: ☐ Self ☐ Child ☒ Other: _____
Secondary:	Group #:	Policy #:	Co-Payment:
Subscriber:	Subscriber SSN:	Subscriber DOB	Patient Relationship to Subscriber: ☒ Self ☐ Child ☐ Other: _____

EMERGENCY CONTACT	
Name of Friend or Relative (Not living at same address):	Relationship to Patient:
Phone Numbers: [Home] [Work] [Cell]	

THE ABOVE INFORMATION IS TRUE AND TO THE BEST OF MY KNOWLEDGE. (Please sign and date below)

_____ _____ _____ _____

Printed Name **Signature** **Relationship to Patient** **Date**