Children's Hospital of The King's Daughters Health System
Children's Medical Group, Inc.

Patient Registration Form

Is this a foster child? Yes No Also known as_____

Patient Demographics

Last Name _____ First Name_____ Middle _____

SSN_____ DOB_____ Sex M F

Address_____

City_____ State_____ Zip_____

Home Ph_____ PCP_____

ADDITIONAL CONTACT (other than parent): Name:_____

Home Ph_____ Work Ph_____

Relationship_____ Cell Ph_____

MOTHER/GUARDIAN

Name_____ H-Ph_____

Address_____ W-Ph_____

City_____ State_____ Zip_____

DOB_____ Cell-Ph_____

SSN_____

Email Address_____

Employer Name_____

FATHER/GUARDIAN

Name_____ H-Ph_____

Address_____ W-Ph_____

City_____ State_____ Zip_____

DOB_____ Cell-Ph_____

SSN_____

Email Address_____

Employer Name_____

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Name_____ Relationship to Patient_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____

SSN_____ DOB_____ EMAIL Address_____

Guarantor's Employer_____

Address_____

City_____ State_____ Zip_____

OTHER FAMILY MEMBERS:	Birthdate	Sex	SSN

PRIMARY INSURANCE

(Please present card for copying)

Insurance Name_____

Subscriber_____

Relationship_____

Subscriber ID_____

Group Number_____

Address_____

City/St/Zip_____

Home Phone_____

Work Phone_____

Subscriber SSN_____

DOB_____

Patient/Member ID_____

SECONDARY INSURANCE

Insurance Name_____

Subscriber_____

Relationship_____

Subscriber ID_____

Group Number_____

Address_____

City/St/Zip_____

Home Phone_____

Work Phone_____

Subscriber SSN_____

DOB_____

Patient/Member ID_____

I verify the above information is accurate

_____ _____

Signature Date

Relationship to patient (Please circle one) – mother father grandparent stepparent legal guardian Other

Office staff/system update completed by_____ **Date**_____ **PT ID #**_____