

Uptown Pediatrics Patient Registration

Patient Information:

First Name _____ Last Name _____ DOB _____
Nickname/ Preferred Name _____
Assigned Gender (on Insurance Card) _____ Preferred Pronouns _____
Home Address _____
Phone _____ Email _____
Patient lives with _____
Siblings (names and DOB) _____

Parent Info:

Parent 1 _____ DOB _____ Phone _____ Email _____
Parent 2 _____ DOB _____ Phone _____ Email _____
(by providing email, parents give consent to receive email updates from Uptown Pediatrics)

Emergency Contact (other than parents):

Name _____ Phone _____ Relationship _____

Preferred Pharmacy:

Name _____ Address _____

Insurance Information:

Primary Health Plan _____ Policy # _____ Group # _____
Primary Policy Holder Name _____ DOB _____
Relationship to Patient _____ Employer _____

If the patient is covered by an additional health plan, provide secondary insurance information

Secondary Health Plan _____ Policy # _____ Group # _____
Policy Holder Name _____ DOB _____
Relationship to Patient _____ Employer _____

How did you learn about Uptown Pediatrics? _____

Endocrine and Allergy Patients Only:

Primary Care Doctor _____ Phone _____

I certify that the information above is complete and correct

Name Signature Date