

**PATIENT REGISTRATION**  
**All About Children Pediatric Partners, P.C.**

**I. PATIENT INFORMATION:**

Patient Name: \_\_\_\_\_ Acct. #: \_\_\_\_\_ Date: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Sex: Male / Female Birth date: \_\_\_\_\_ Age: \_\_\_ yrs \_\_\_ mos  
Person with whom Child lives: (Mother / Father / Grandparent / Foster Parent / Guardian / Other: \_\_\_\_\_)  
Address: \_\_\_\_\_  
E-mail: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_  
Sibling Names: \_\_\_\_\_  
Mother Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Father Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**II. INSURANCE INFORMATION:**

Primary Insurance: Start date: \_\_\_\_\_ Termination date: \_\_\_\_\_ Copay: \$ \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Policy Holder Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Birth date: \_\_\_\_\_  
Relationship to patient: (Mother / Father / Patient / Other \_\_\_\_\_) Contact Phone on Ins Card: \_\_\_\_\_  
Employer: \_\_\_\_\_ Employer phone number: \_\_\_\_\_  
Secondary Insurance: Start date: \_\_\_\_\_ Termination date: \_\_\_\_\_ Copay: \$ \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Policy Holder Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Birth date: \_\_\_\_\_  
Relationship to patient: (Mother / Father / Patient / Other \_\_\_\_\_) Contact Phone on Insurance Card: \_\_\_\_\_  
Employer: \_\_\_\_\_ Employer phone number: \_\_\_\_\_  
ACCESS (PA Medicaid) Number: \_\_\_\_\_

**III. MEDICAL INFORMATION ABOUT PATIENT: Allergies: \_\_\_\_\_**

Has s/he ever had Chickenpox disease? (Circle): Yes / No Birthplace (State or Country): \_\_\_\_\_

Race (Please circle ALL that apply):  
White (Caucasian) / Black (African) / Asian / Middle Eastern / Native American / Polynesian / Other: \_\_\_\_\_  
Hispanic: (Please circle origin also): Central American, Cuban, Mexican, Puerto Rican, South American, \_\_\_\_\_  
Other ( please specify ) \_\_\_\_\_

Language: English, Spanish, Arabic, Cambodian, Chinese, French, German, Greek, Pashto, Polish, Romanian, Russian, Turkish, Vietnamese, Other (Please specify): \_\_\_\_\_

**IV. AUTHORIZATION:**

- I authorize any treatment needed for the proper care of my child by All About Children Pediatric Partners, PC.
- I authorize payment by my insurance company directly to AACPP of any medical/surgical benefits for the services rendered.
- I understand that I am financially responsible to AACPP for all payments due which are not covered by the applicable insurance plan(s).
- I authorize the release of any information acquired in the course of my examination or treatment to all of my covering insurance companies to process my claims and/or to a legitimate medical professional if such referral is necessary.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Rev: 5/6/09