Rise & Shine Pediatrics, PC

Registration Form

PATIENT INFORMATION			
Child's Legal Name:			DOB:
Street Address:		City, State, Zip:	
Gender: ☐ MALE ☐ FEMALE		Primary Phone:	
Race:	Ethnicity:	Language:	

PARENT/GUARDIAN INFORMATION	
Mothers Name:	Father Name:
DOB:	DOB:
Street Address:	Street Address:
City, State, Zip:	City, State, Zip:
SSN:	SSN:
Home/Cell Phone:	Home/Cell Phone:
Work Phone:	Work Phone:
Preferred Email Address:	

GUARANTOR INFORMATION (TO WHOM STATEMENTS ARE SENT)		
☐ Mother ☐ Father ☐ Guardian/other _____		
Guarantors Name:		
Billing Address (If different from Patient):		
Home/Cell Phone:	SSN:	DOB:

EMERGENCY CONTACT INFORMATION	
Contact Name:	Contact Relation:
Primary Number:	Secondary Number:

PRIMARY INSURANCE		
Insurance Plan Name:		
POLICY HOLDER INFORMATION		
Policy Holder Name:	DOB:	SSN:
Subscriber ID#:	Policy/Group#:	
Relationship to Child:	Gender: ☐ M ☐ F	Phone:

SECONDARY INSURANCE		
Insurance Plan Name:		
POLICY HOLDER INFORMATION		
Policy Holder Name:	DOB:	SSN:
Subscriber ID#:	Policy/Group#:	
Relationship to Child:	Gender: ☐ M ☐ F	Phone:

I certify that the above information is accurate and complete.

X _____

Parent/Guardian Signature Printed Name Date