Greeley County Health Services

Serve with Compassion & Excellence

PEDIATRIC REGISTRATION FORM

Patient's Name _____ **Birthdate** _____
(First, middle, and last name as it appears on insurance cards)

SSN #:_____ **Sex**: Male / Female **Primary Language:** _____

Race: White / Asian / Black / Hispanic / More than One / Other
Ethnicity: Hispanic / Non-Hispanic / Unknown

Child's Home Address : _____
ADDRESS CITY/STATE/ ZIP

Parent/Guardian 1_____ **Relation to patient**_____
(First, middle, and last name)
Lives with patient? Yes / No Birthdate_____SSN #_____

Home Phone (_____)_____ **Email address** _____

Employer: _____ **Phone #** _____**Ext.**_____

Parent/Guardian 2_____ **Relation to patient** _____
(First, middle, and last name)
Lives with patient? Yes / No Birthdate_____SSN #_____

Home Phone (_____)_____ **Email address** _____

Employer: _____ **Phone #** _____**Ext.**_____

Parent/Guardian 3_____ **Relation to patient**_____
(First, middle, and last name)
Lives with patient? Yes / No Birthdate_____SSN #_____

Home Phone (_____)_____ **Email address** _____

Employer: _____ **Phone #** _____**Ext.**_____

Emergency Contact 1:_____ **Relation to Patient** _____
(Other than guardian) (First, middle, and last name)

Lives with patient? Yes / No **Birthdate** _____ **Home Phone #** _____

Cell Phone # _____ **Email address** _____

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INSURANCE INFORMATION

(GIVE INSURANCE CARD(S) TO RECEPTIONIST)

See scanned insurance card _____

Primary Insurance Company _____ Group # _____

Subscriber's Name _____ DOB:_____ID # _____
(First, middle, and last name as it appears on insurance cards)

Employer's Name _____

Secondary Insurance Company _____ Group # _____

Subscriber's Name _____DOB:_____ ID # _____
(First, middle, and last name as it appears on insurance cards)

Employer's Name _____

Patient or Personal Representative Signature: _____

Date: _____