Good Night Pediatrics

Patient Registration

Patient ID:_____
(to be completed by staff)

Today's Date: _____
Have we seen this patient in the last three years? Yes No Previous name _____

Patient Information:

Name: Last_____ First _____MI_____

Date of Birth _____/_____/_____Sex _____Patient's Social Security #: _____-____-_____

Marital Status: ___Single ___Married ___Divorced ___Widow ___Significant other

Street Address_____ Apt / Lot _____

City _____ State_____ Zip Code _____

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Email Address_____ Would you like portal access? ___Yes ____ No

Primary care physician (PCP) _____ Phone: (____) _____
Primary Care address / location _____
(Information concerning your care provided by this center will be forwarded to your PCP unless otherwise specified)

Preferred Language: _____ Religion _____

Race: please select one

____ American Indian or Alaska Native _____ Asian
____ Black or African American _____ Native Hawaiian or Other Pacific Islander
____ White _____ Decline to answer

Ethnicity: please select one : ___ Hispanic or Latino ___ Non-Hispanic or Latino ___Decline to answer

Preferred Method of contact _____ Okay to leave a message ___Yes ___No

Preferred Pharmacy _____ Address _____

Parent / Legal Guardian Information - if address is the same above, write "SAME" as street address

Name: Last_____ First _____MI_____

Date of Birth _____/_____/_____Sex _____ Social Security #: _____-____-_____

Marital Status: ___Single ___Married ___Divorced ___Widow ___Significant other

Street address_____ Apt / Lot#_____

City_____ State_____ Zip code_____

Phone: Home (____) _____ Cell (____) _____Work (____) _____

Relationship to patient:_____

Person to contact in case of an emergency if unable to reach the parent/legal guardian listed above.

Name: _____ Relationship to Patient: _____

Street address_____ Apt / Lot#_____

City_____ State_____ Zip code_____

Phone: Home (____) _____ Cell (____) _____Work (____) _____

Source Information

How did you hear about us? _____

PRIMARY INSURANCE: Although we scan your insurance cards not all the information necessary to file a claim is on the card. Please complete <u>all</u> the information below. ***If the information is not complete, the account will be set as self-pay and you will be responsible for the charges until we have the information necessary to file a claim****. For commercial insurance you will be reimbursed any overpayment after the claim has been processed by the insurance. For Medicaid / AHCCCS, you will be reimbursed after we are able to verify eligibility.*

Insurance Company Name: _____

Insurance Plan: _____

Claim Address: Street _____ Suite: _____

City: _____ State: _____ Zip Code: _____

Verification Phone: _____ Member ID # _____

Group #:_____ Group Name: _____

Effective date: _____ Term Date: _____

Insured / Policy Holder Name: _____

Street address_____ Apt / Lot#_____

City_____ State_____ Zip code_____

Insured's Date of Birth: ___/____/____ Patient Relationship to Insured: ___Self __Spouse___ Dependent

Insured's Employer: _____

Military Branch: _____Status: _____ Rank: _____

Secondary Insurance:

Insurance Company Name: _____

Insurance Plan: _____

Claim Address: Street _____ Suite: _____

City: _____ State: _____ Zip Code: _____

Verification Phone: _____ Member ID # _____

Group #:_____ Group Name: _____

Effective date: _____ Term Date: _____

Insured / Policy Holder Name: _____

Street address_____ Apt / Lot#_____

City_____ State_____ Zip code_____

Insured's Date of Birth: ___/____/____ Patient Relationship to Insured: ___Self __Spouse___ Dependent

Insured's Employer: _____

Military Branch: _____Status: _____ Rank: _____