HARBOR PEDIATRICS PATIENT REGISTRATION

PLEASE COMPLETE THE FORM AND PROVIDE YOUR HEALTH INSURANCE CARD

Date:_____

Patient's Last Name:_____Middle Initial: _____First Name:_____
Preferred Name (if applicable):_____

Date of Birth:_____Sex: _____ Current Age:_____

Patient's Mailing Address:_____
Street address/PO Box City State zip code

Is your mailing address the same as your physical address? (circle one) YES NO
If no, please provide physical address:_____

*If patient is under 18 years old, please provide parental information:
Parent #1 Name (primary contact): _____
Home Phone:_____Work Phone:_____Cell_____
Email:_____
Would you like to be automatically registered to the patient portal with this email?_____

Parent #2 Name:_____
Home Phone:_____Work Phone:_____Cell_____
Email:_____
Would you like to be automatically registered to the patient portal with this email?_____

Guardian (if not parent): _____

Usual Provider: Dr. Scarponi Emily Kilroy, NP

Preferred Pharmacy:_____

Emergency Contact Name (other than parent #1/#2):_____
Relationship:_____
Emergency Contact Phone: _____

Authorization to disclose information: I give Harbor Pediatrics permission to speak to:
(please provide name and phone number)
_____

- ❏ Medical information AND/OR
- ❏ Billing information

COMMUNICATION PREFERENCE

(general communication between office and patient/guardian)

Consent to call? (automated phone calls from the office to your primary cell phone) YES NO
Consent to text? (automated texts from the office to your primary cell phone) YES NO
Contact preference (circle one): Parent #1 or #2 HOME WORK CELL MAIL PORTAL

DEMOGRAPHICS

Language:_____ Do you require a translator? YES NO

Race (circle one): White/Caucasian American Indian/Alaska Native Asian Black/African American
Native Hawaiian/Other Pacific Islander Hispanic Refuse to report

Ethnicity (circle one): Hispanic/Latino Non-Hispanic/Non-Latino unknown Refuse to report

INSURANCE

Primary Insurance Name: _____

Policy #: _____

Group #: _____

Policy Holder (guarantor) Name: _____

- ❏ Self

Address of policy holder (guarantor):_____

- ❏ Same as home address

Home phone:_____ E-mail_____

DOB of policy holder (guarantor):_____

SSN _____

Relationship of guarantor to patient: _____

Employer name of policy holder (guarantor):_____

Secondary Insurance Name:_____
Policy #: _____Group #: _____
Policy Holder (guarantor) Name: _____