Children's Dermatology Services

Wexford, PA 1

724-933-9

NEW PATIENT REGISTRATION FORM (pg 1)

Patient's Information					
Last Name	First Name	MI	D.O.B. _____/_____/_____	Gender M or F	SS# _______--______--________

#1 Guardian/ Parent	☐ Check here if this person is the insurance carrier				
Last Name	First Name	MI	Relationship	SS# _______--______--________	
Street Address	City	State	Zip	Employer	Occupation
Home Phone	Cell Phone	Work Phone	E-mail Address	D.O.B. _____/_____/_____	

#2 Guardian/ Parent	☐ Check here is if this person is the insurance carrier				
Last Name	First Name	MI	Relationship	SS# _______--______--________	
Street Address	City	State	Zip	Employer	Occupation
Home Phone	Cell Phone	Work Phone	E-mail Address	D.O.B. _____/_____/_____	

#3 Guardian/ Parent	☐ Check here if this person is the insurance carrier				
Last Name	First Name	MI	Relationship	SS# _______--______--________	
Street Address	City	State	Zip	Employer	Occupation
Home Phone	Cell Phone	Work Phone	E-mail Address	D.O.B. _____/_____/_____	

# 1 Insurance Company Information				
Insurance carrier's name	D.O.B. _____/_____/_____	Insurance Company Name		
Policy Effective Date _____/_____/_____	Policy/ ID#	Group Policy Number	Ins Employer	
Ins Address	Ins City	State	Ins Zip	Ins Phone

#2 Insurance Company Information				
Insurance carrier's name	D.O.B. _____/_____/_____	Insurance Company Name		
Policy Effective Date _____/_____/_____	Policy/ ID#	Group Policy Number	Ins Employer	
Ins Address	Ins City	State	Ins Zip	Ins Phone

Pediatrician / PCP			
Physician's Name	Office/ Practice Name	Telephone Number	
Street Address	City	State	Zip

PAYMENT OF BENEFITS AND RELEASE OF MEDICAL INFORMATION:

I authorize the release of many medical information necessary to process insurance claims and request payment of insurance to Children's Community Pediatrics.

Signature: Date

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NEW PATIENT REGISTRATION FORM (pg 2)

Patient's Information

Last Name	First Name	Age Today	Gender M or F	Reason for Visit

Pharmacy Information

Pharmacy Name	Phone Number

Patient's Medical Conditions & Medicines

Condition # 1	Medicine 1	Medicine 2	Medicine 3
	Medicine 4	Medicine 5	Medicine 6
Condition # 2	Medicine 1	Medicine 2	Medicine 3
	Medicine 4	Medicine 5	Medicine 6
Condition #3	Medicine 1	Medicine 2	Medicine 3
Condition #4	Medicine 1	Medicine 2	Medicine 3

Others

Allergies

To Medicines	Reaction	To Food or Enviroment	Reaction
	→		→
	→		→
	→		→
	→		→
	→		→

Medical Permission Information

What brought you to our clinic: ☐ Self-referred ☐ Pediatrician referred ☐ Seen as in-patient by our physicians

Patient or Guardian (Parent) Signature

Signature: Today's Date