SOUTH TEXAS CENTER FOR PEDIATRIC CARE

NEW PATIENT REGISTRATION FORM

DATE _____/_____/_____ STCPC OFFICE: _____

PATIENT INFORMATION:

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

DOB _____ SEX: M_____ F_____

ADDRESS _____ CITY _____ ST _____ ZIP _____

HOME #_____ WORK #_____ CELL #_____

PARENT / GUARDIAN INFORMATION:

FATHER LAST NAME _____ FIRST NAME _____ MI _____ DOB_____

ADDRESS _____ CITY _____ ST _____ ZIP _____

HOME #_____ WORK #_____ CELL #_____

EMAIL ADDRESS: _____

MOTHER LAST NAME _____ FIRST NAME _____ MI _____ DOB_____

ADDRESS _____ CITY _____ ST _____ ZIP _____

HOME #_____ WORK #_____ CELL #_____

EMAIL ADDRESS: _____

EMERGENCY CONTACT PERSON _____ RELATIONSHIP TO PATIENT_____

ADDRESS _____ CITY_____ST _____ ZIP _____

HOME #_____ WORK #_____ CELL # _____

INSURANCE INFORMATION:

PRIMARY INSURANCE _____

INSURANCE HOLDER NAME _____ INSURANCE HOLDER DOB _____

INSURANCE ID _____ GROUP # _____

SECONDARY INSURANCE _____

INSURANCE HOLDER NAME _____ INSURANCE HOLDER DOB _____

INSURANCE ID _____ GROUP # _____

WOULD YOU LIKE TO RECEIVE STATEMENTS BY EMAIL? Y_____ N_____

PARENT OR LEGAL GUARDIAN SIGNATURE_____