BMG | BAPTIST MEDICAL GROUP

PEDIATRIC REGISTRATION

MRN___________________________

Date_______________ Referring Physician ____________________________ Primary Care Physician _______________________

Patient Last Name________________________ First Name ____________________ Middle Initial_____ Suffix _____(Jr/Sr/II etc.)

Address ___________________________ City______________________ State________Zip ___________ County _________________

Patient's Nickname ________________ Home Phone______________________ ☐ Male ☐ Female Date of Birth _____/_____/_____

Patient's Soc. Sec. # __________________________

Preferred Language: ☐ English ☐ Spanish ☐ Other_______________________________________

Race: ☐ Ame. Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ White/Not Hispanic ☐ Other______________________

Ethnic Background: ☐ Hispanic/Latino ☐ Not Hispanic/Not Latino ☐ Other____

Pharmacy Name ____Pharmacy Phone___________________________________

Parent/Guardian Information/Responsible Party Information

MOTHER

Last Name______________________________ First Name ____________________ Middle Initial_____ Suffix _____(Jr/Sr/II etc.)

Mother's DOB:___________________________

Address ____________________________________ City___________________________ State ___________Zip _________________

Home phone ______________________ Work phone _________________________ext._______ Cell phone ______________________

Parent E-mail Address ____

Employer ____ Employer Address____

FATHER

Last Name______________________________ First Name ____________________ Middle Initial_____ Suffix _____(Jr/Sr/II etc.)

Father's DOB: ___________________________

Address ____________________________________ City___________________________ State ___________Zip _________________

Home phone ______________________ Work phone _________________________ext._______ Cell phone ______________________

Employer ____ Employer Address____

Emergency Contact

Name____ Relationship _____________________Phone __________________________

Emergency Contact Other Than Responsible Party

Name _____________________________ Relationship___________ Home phone__________________Cell Phone________________

Primary Insurance

Insurance Co. ___________________________ Copay________

Group # _________________Policy # ______________________

Subscriber _________________ Date of Birth: ____/____/____

Relationship to Patient: ___________________________________

Secondary Insurance

Insurance Co. ____

Group # _________________Policy # ______________________

Subscriber _________________ Date of Birth: ____/____/____

Relationship to Patient: ___________________________________

I give my permission to release my child's immunization record to his/her daycare, school, camp, and/or sport program upon request.

____ ____

Signature of parent/guardian/person authorized to sign for patient *Date*

Form #21-102.3 (02/14)