Monroe Pediatric Associates, P.C.

A Division of Allied Pediatrics of New York
70 Gilbert Street · Monroe, NY 10950
(845)782-8616

FAMILY REGISTRATION FORM

Please fill out completely for <u>each</u> child who is a patient at Monroe Pediatrics. Additional forms available if required. If parental information or policy holder information is the same for subsequent children, Please check "SAME" box.

CHILD #1 (Name as it appears on Birth Certificate)

First: _____ Middle: _____ Last: _____

Gender: Male Female DOB: _____ Mother's Maiden Name: _____

Any Custody Issues? Yes No If Yes, please describe: _____ Preferred Contact # _____

Address: _____ Apt. # _____ City: _____ State: _____ Zip: _____

PARENT #1 (At Child's Address) Please circle one: Biological Adoptive Legal Guardian Foster Step

First: _____ M.I. _____ Last: _____

DOB: _____ SSN: _____ Employer: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Phone (w/ area code): (Home) _____ (Cell)_____ (Work) _____

PARENT #2 (At Child's Address) Please circle one: Biological Adoptive Legal Guardian Foster Step

First: _____ M.I. _____ Last: _____

DOB: _____ SSN: _____ Employer: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Phone (w/ area code): (Home) _____ (Cell)_____ (Work) _____

BIOLOGICAL/ADOPTIVE PARENT INFORMATION (If not listed above) ☐ **Not Applicable**

<u>Mother</u> - First: _____ M.I. _____ Last: _____

Address: _____ Apt.# ____ City: _____ State: _____ Zip: _____

DOB: _____ SSN: _____ Employer: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Phone (w/ area code): (Home) _____ (Cell)_____ (Work) _____

<u>Father</u> - First: _____ M.I. _____ Last: _____

Address: _____ Apt.# ____ City: _____ State: _____ Zip: _____

DOB: _____ SSN: _____ Employer: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Phone (w/ area code): (Home) _____ (Cell)_____ (Work) _____

CHILD'S INSURANCE INFORMATION (Highlighted areas required for each child)

***Primary Insurance*: _____ Child's ID# _____ Group# _____**

Policy Holder: _____ DOB: _____ SSN: _____ Relationship to Patient: _____

Policy Holder's Address: _____City:_____ State: ____ Zip: _____ Insurance thru Employer: Yes No

Employer: _____ Employer's Address: _____ City: _____ State: _____ Zip: _____

***Secondary Insurance*: _____ Child's ID# _____ Group# _____**

Policy Holder: _____ DOB: _____ SSN: _____ Relationship to Patient: _____

Policy Holder's Address: _____City:_____ State: ____ Zip: _____ Insurance thru Employer: Yes No

Employer: _____ Employer's Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: Name:_____ Home:_____ Cell:_____

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FAMILY REGISTRATION FORM

If parental information or policy holder information is the same for subsequent children, Please check "SAME" box.

CHILD #2 (Name as it appears on Birth Certificate)

First: _____ Middle: _____ Last: _____

Gender: Male Female DOB: _____ Mother's Maiden Name: _____

Any Custody Issues? Yes No If Yes, please describe: _____ Preferred Contact # _____

Address: _____ Apt. # _____ City: _____ State: _____ Zip: _____

PARENT #1 (At Child's Address) Please circle one: Biological Adoptive Legal Guardian Foster Step ☐ SAME

First: _____ M.I. _____ Last: _____

DOB: _____ SSN: _____ Employer: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Phone (w/ area code): (Home) _____ (Cell)_____ (Work) _____

PARENT #2 (At Child's Address) Please circle one: Biological Adoptive Legal Guardian Foster Step ☐ SAME

First: _____ M.I. _____ Last: _____

DOB: _____ SSN: _____ Employer: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Phone (w/ area code): (Home) _____ (Cell)_____ (Work) _____

BIOLOGICAL/ADOPTIVE PARENT INFORMATION (If not listed above) ☐ Not Applicable

Mother - First: _____ M.I. _____ Last: _____

Address: _____ Apt.# ____ City: _____ State: _____ Zip: _____

DOB: _____ SSN: _____ Employer: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Phone (w/ area code): (Home) _____ (Cell)_____ (Work) _____

Father - First: _____ M.I. _____ Last: _____

Address: _____ Apt.# ____ City: _____ State: _____ Zip: _____

DOB: _____ SSN: _____ Employer: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Phone (w/ area code): (Home) _____ (Cell)_____ (Work) _____

CHILD'S INSURANCE INFORMATION (Highlighted areas required for each child) ☐ SAME - Policy Holder Information

Primary Insurance: _____ **Child's ID#** _____ **Group#** _____

Policy Holder: _____ DOB: _____ SSN: _____ Relationship to Patient: _____

Policy Holder's Address: _____City:_____ State: ____ Zip: _____ Insurance thru Employer: Yes No

Employer: _____ Employer's Address: _____ State: _____ Zip: _____

Secondary Insurance: _____ **Child's ID#** _____ **Group#** _____

Policy Holder: _____ DOB: _____ SSN: _____ Relationship to Patient: _____

Policy Holder's Address: _____City:_____ State: ____ Zip: _____ Insurance thru Employer: Yes No

Employer: _____ Employer's Address: _____ State: _____ Zip: _____

I authorize the release of any medical or other information necessary to process a claim. I understand and agree that I am responsible for the balance of my account for any professional services including any unmet deductibles, copayments and non-covered services. I authorize payment of benefits directly to the physician if necessary. I further understand that in the event this account is turned over to attorney for collection, I will be responsible for reasonable attorney's fees and all costs of collection.

Parent/Guardian Signature:_____ Date:_____