PATIENT REGISTRATION

Tammy Maschino, M.D.
Kimberly Edgmon, M.D.
Karyl Knopps, APRN-CNP

Patient Information
First Name: ________________________________ Middle Name: __________________ Last Name: _____________________
Birthdate: _________________________________ Sex: ______________ Email: _____________________________________
Address: ____ City: _______________ State: _____ Zip: ____________________

Parent Information
Mother: ☐ **Biological** ☐ **Step** ☐ **Foster** ☐ **Grandparent** ☐ **Adoptive** ☐ **Legal Guardian** ☐ **Other**
Mothers Name: ____________________________ Middle Initial: ____ Birthdate: _____________ SS#: __________________
Address: ____ City: ______________ State: ______ Zip: ___________________
Occupation: ___________________________________ Employer: ____
Home Phone: ___________________________________ Work Phone: ____
Cell Phone: _____________________________________ Email: ____

Father: ☐ **Biological** ☐ **Step** ☐ **Foster** ☐ **Grandparent** ☐ **Adoptive** ☐ **Legal Guardian** ☐ **Other**
Fathers Name: __________________________________ Middle Initial: ______ Birthdate: _______________________________
Address: ____ City: _______________ State: ______ Zip: ___________________
Occupation: ___________________________________ Employer: ____
Home Phone: ___________________________________ Work Phone: ____
Cell Phone: ____________________________________ Email: ____

Insurance: ____
Subscriber Name: ____ Subscriber Birthdate: ______________________________

Family Members
Sibling Name: ____ Birthdate: _______________________________
Sibling Name: ____ Birthdate: _______________________________

In Case of Emergency Notify (Please list someone living outside of home)
1. ____ Relationship: _____________________ Phone: ______________________
2. ____ Relationship: _____________________ Phone: ______________________

Other
How did you hear about our clinic? ____
Who was your child's previous pediatrician? ____

Insurance Authorization Assignment:
I hereby authorize Dr. Tammy Maschino, Dr. Kimberly Edgmon and/or Karyl Knopps, APRN-CNP to furnish information to insurance carriers concerning my child's illnesses and treatments and hereby assign to the doctor all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

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Parent/Guardian Signature **Date**