PATIENT REGISTRATION

Tammy Maschino, M.D.
Kimberly Edgmon, M.D.
Susan White, M.D.
Jessica Yocum, M.D.
Lauren Adams, 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, Dr. Susan White, Dr. Jessica Yocum, and/Lauren Adams, 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.

Parent/Guardian Signature **Date**