



## Patient Registration Form

### Welcome to KidsWatch Pediatrics & Urgent Care!

Please complete all sections of this form. Accurate information is essential for providing you with the best possible care. If you have any questions, please don't hesitate to ask our staff.

#### Section 1: Patient Information

- **Legal Name:**  
\_\_\_\_\_
- **Preferred Name (if different):** \_\_\_\_\_
- **Date of Birth (MM/DD/YYYY):** \_\_\_\_\_
- **Sex:**  Male  Female
- **Social Security Number (Optional):**  
\_\_\_\_\_
- **Marital Status:**  Single  Married  Divorced  Widowed  Other
- **Address:** \_\_\_\_\_
- **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_
- **Phone Number (Home):** \_\_\_\_\_
- **Phone Number (Work):** \_\_\_\_\_
- **Phone Number (Mobile):** \_\_\_\_\_
- **Email Address:**  
\_\_\_\_\_
- **Preferred Method of Contact:**  Phone  Email  Text

**Section 2: Emergency Contact Information**

- Name: \_\_\_\_\_
- Relationship to Patient: \_\_\_\_\_
- Phone Number: \_\_\_\_\_
- Address (if same as patient, check here 

**Section 3: Insurance Information**

- Primary Insurance Company:  
\_\_\_\_\_
- Member ID: \_\_\_\_\_
- Group Number: \_\_\_\_\_
- Policy Holder Name:  
\_\_\_\_\_
- Policy Holder Date of Birth: \_\_\_\_\_
- Secondary Insurance Company (if applicable):  
\_\_\_\_\_
- Member ID: \_\_\_\_\_
- Group Number: \_\_\_\_\_
- Policy Holder Name:  
\_\_\_\_\_
- Policy Holder Date of Birth: \_\_\_\_\_

**Section 4: Medical History**

- Primary Care Physician (if applicable):  
\_\_\_\_\_
- List any current medical conditions:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- List any past medical conditions or surgeries:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- **List any allergies (medications, food, environmental):**

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- **List any current medications (prescription and over-the-counter):**

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**Section 5: Authorization and Acknowledgement**

- I authorize KidsWatch Pediatrics & Urgent Care to release my medical information to my insurance company for billing purposes.
- I understand that I am responsible for any co-pays, deductibles, or other charges not covered by my insurance.
- I have received a copy of KidsWatch Pediatrics & Urgent Care's Notice of Privacy Practices (HIPAA).
- I consent to receive communications from KidsWatch Pediatrics & Urgent Care regarding my healthcare via (check all that apply):  Phone  Email  Text
- I certify that the information I have provided on this form is true and accurate to the best of my knowledge.

**Guarantor/Patient Signature:**

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**Date:** \_\_\_\_\_

**Printed Name:**

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**Staff Use Only:**

- **Date Received:** \_\_\_\_\_
- **Entered By:** \_\_\_\_\_
- **Insurance Verified:**  Yes  No
- **Notes:**

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**Thank you for choosing KidsWatch Pediatrics & Urgent Care for your healthcare needs!**