Mercer Island Pediatric Associates, Inc. P.S.
REGISTRATION FORM

ID#

Today's Date

Physician

PATIENT INFORMATION

Patient's last name:	First:	MI	Birth Date:	Sex:	Patient's cell:
Street Address:	SSN:		Home phone:		
City:	State:	ZIP			
Sibling names/DOB:					

PARENT INFORMATION

MOTHER/GUARDIAN			FATHER/GUARDIAN		
name:			name:		
Address (if different from patient)			Address (if different from patient)		
Home phone:	Work :	Cell :	Home phone:	Work :	Cell :
Employer:	Occupation:		Employer:	Occupation:	
Emp. Address:			Emp. Address:		
Relation to Pt:	DOB:		Relation to Pt:	DOB:	
Send bills to this address	Yes ☐	No ☐	Send bills to this address	Yes ☐	No ☐

INSURANCE INFORMATION

Is this patient covered by insurance? Yes ☐ No ☐ Please give your insurance card to the receptionist.

Primary insurance	Group no.:	Policy no.:	Co-payment:
Subscriber's name:	Subscriber's SSN	DOB	

Pt's relationship to Subscriber: ☐ Self ☐ Child ☐ Other

Secondary insurance:	Group no.:	Policy no.:	Co-payment:
Subscriber's name:	Subscriber's SSN	DOB	

Pt's relationship to Subscriber: ☐ Self ☐ Child ☐ Other

EMERGENCY CONTACTS

Name of local friend or relative (not living at same address):

_______________ Relationship to Patient _______________

Phones: [H]_______________ [W] _______________ [C] _______________

The above information is true to the best of my knowledge.

Name	Signature	Relationship to Patient	Date