kids first pediatrics

New Patient Registration

Insurance card and driver's license are required upon each visit at check-in.

Last Name_____ First Name_____ Middle Initial_____
Date of Birth ___/___/___ Age___ Gender: M/F ___ Sibling Names_____
Street Address_____ City_____ Zip Code_____
Email Address for Patient Portal, Reminders & Receipts_____

To plan for the support and development of a healthcare system that meets the current and future needs of our patients, we ask for the following information:

Race: ☐American Indian/Alaska Native ☐Asian ☐African-American/Black
☐Caucasion/White ☐Native Hawaiian/Other Pacific Islander ☐Decline

Ethnicity: ☐Hispanic ☐Non-Hispanic Preferred Language:_____

<u>Parent Information – Primary Insured</u>
Last Name_____ First Name_____ Middle Initial_____
Date of Birth ___/___/___ SS#_____-_____-_____
Primary Phone_____ Alternate Phone_____
Street Address_____ City_____ Zip Code_____
Employer_____ Employer Phone_____

<u>Spouse or Other Guarantor Information</u>
Last Name_____ First Name_____ Middle Initial_____
Date of Birth ___/___/___ SS#_____-_____-_____
Primary Phone_____ Alternate Phone_____
Street Address_____ City_____ Zip Code_____
Employer_____ Employer Phone_____

Please check <u>first</u> preference for provider: ☐Dr. Badaracco ☐Dr. Conger ☐Dr. Kelkar ☐Dr. Sias
☐Leigh Gistinger, NP ☐Missy Nicholson, NP ☐Sarah Caudle, PA ☐Dr. Della Nebbia

How did you hear about us?
☐Friend Referral (Name_____) ☐Physician Referral (Name_____)
☐Internet (Search Engine_____) ☐Insurance Referral ☐Sibling Already Patient
☐Returning Patient Please list if other referral_____

Fax: (972) 317-8503