Wee Care Pediatrics

Patient Registration Form

Patient Information

Patients Legal Last Name	Legal First Name	M.I.	Patients Date of Birth	Gender ☐M ☐ F	Primary Care Physician

Street Address	City	State	Zip

Home Number	Cell Number	Preferred Pharmacy	Pharmacy Location

Emergency Contact Name (Not living with you)	Relationship to patient	Emergency Contact Phone Number

Preferred Communications (Please Select One)	Ethnicity	Race	Preferred Language
☐ Phone ☐ Email ☐ Text ☐ Fax ☐ Mail ☐Website	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined	☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black ☐ African American ☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ Declined	

Parent/Responsible Party Information

Legal Last Name	Legal First Name	M.I.	Date of Birth	Gender ☐M ☐ F	SSN

Preferred Name	Relationship to Patient	Email
	☐ Parent ☐ Step-Parent ☐ Legal Guardian ☐ Other_______________	

Street Address (If different than patients)	City	State	Zip

Home Number	Cell Number	Preferred Communications (Please Select One)
		☐ Phone ☐ Email ☐ Text ☐ Fax ☐ Mail ☐Website

Responsible Party Employer	Occupation	Responsible Party Work Phone/Ext.

Second Parent/Responsible Party Information

Legal Last Name	Legal First Name	M.I.	Date of Birth	Gender ☐M ☐ F	SSN

Preferred Name	Relationship to Patient	Email
	☐ Parent ☐ Step-Parent ☐ Legal Guardian ☐ Other_______________	

Street Address (If different than patients)	City	State	Zip

Home Number	Cell Number	Preferred Communications (Please Select One)
		☐ Phone ☐ Email ☐ Text ☐ Fax ☐ Mail ☐Website

Responsible Party Employer	Occupation	Responsible Party Work Phone/Ext.

Primary Insurance Information

Insurance Company	ID (Policy Number)	Group Number	Copay	Effective Date

Subscriber	Relationship to Patient	Subscribers Date of Birth
	☐ Parent ☐ Step-Parent ☐ Legal Guardian ☐ Other_______________	

Subscribers Employer	Subscriber's SSN	

Secondary Insurance Information

Insurance Company	ID (Policy Number)	Group Number	Copay	Effective Date

Subscriber	Relationship to Patient	Subscribers Date of Birth
	☐ Parent ☐ Step-Parent ☐ Legal Guardian ☐ Other_______________	

Subscribers Employer	Subscriber's SSN	

Authorized Signature_________________________________ **Date**______________________________

Please bring this form along with your picture ID, insurance card(s) and applicable copay(s) to your appointment.