CrescentCare
A Partnership for Life

PEDIATRIC PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name	Preferred Name	Social Security #	Gender Preference ☐ M ☐ F ☐ Transgender (M to F) ☐ Transgender (F toM) ☐ Choose Not to Disclose	Date of Birth (MM/DD/YY)
Preferred Language			Interpreter Needed? ☐ Yes ☐ No	U.S. Citizen? ☐ Yes ☐ No
Patient Race/Ethnicity – Select all that apply. ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White/Caucasian ☐ Other ☐ More than one race Is the patient Hispanic? ☐ Yes ☐ No			Type of Housing ☐ Own ☐ Subsidized ☐ Other Shelter ☐ Rent ☐ Transitional Housing ☐Homeless ☐ Staying with Friends/Family	
In case a parent can't be contacted, please list an alternative Emergency Contact.		Relationship to Patient		Emergency Contact Phone

PARENT/GUARDIAN INFORMATION

Parent 1/Guardian Name		Mother/Guardian Email Address		
Parent 1/Guardian Address		City	State	ZIP
Parent 1/Guardian Primary Phone	Secondary Phone	Preferred Contact Method ☐ Mail ☐ Primary Phone ☐ Secondary Phone ☐ E-Mail		
Parent 2 /Guardian Name		Father/Guardian Email Address		
Parent 2 /Guardian Address		City	State	ZIP
Parent 2 /Guardian Primary Phone	Secondary Phone	Preferred Contact Method ☐ Mail ☐ Primary Phone ☐ Secondary Phone ☐ E-Mail		

INSURANCE & GUARANTOR INFORMATION

Primary Insurance		Policy #	Group #
Subscriber Name		Relationship to Patient	
Secondary Insurance (if applicable)		Policy #	Group #
Subscriber Name		Relationship to Patient	
Guarantor/Name of Person Responsible for Payment (if different from Subscriber)			
Address	City	State	ZIP
Phone	Relationship to Patient		

Parent/Guardian Signature	Relationship to Patient	Date