Texas Children's® Pediatrics

Date Completed
Primary Care Provider

Patient Registration Form (Please fill in all fields completely)

Patient Information

Child's Full Legal Name (Last, First, Middle)	Date of Birth	Sex	Preferred Name
Other Children in family:			
Child's Street Address (City, State, Zip Code)	Telephone#where child lives	Parent's Work # ☐Mom ☐Dad	Parent's Email Address: ☐ Mom ☐ Dad

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian and other Pacific Islander ☐ White

Ethnic Group: ☐ Hispanic ☐ Non-Hispanic

Patient's Primary Language: English ____ Spanish ____ Other _____

Parent's/Legal Guardian's Primary Language: English ____ Spanish ____ Other _____

Does the parent/legal guardian require an interpreter? Yes ☐ No

If there is insurance for child/children, please present the insurance card to the check-in staff.

Emergency Contacts

Mother's Name (Last, First, Middle)	Home #	Work #	Cell #
Home Address (City, State, Zip Code) (if different from above)			
Father's Name (Last, First, Middle)	Home #	Work #	Cell #
Home Address (City, State, Zip Code) (if different from above)			
Additional Contact (Last, First, Middle)	Home #	Work #	Cell # (Relationship to Patient)
Home Address (City, State, Zip Code)			

Who may we thank for referring you to our practice?	**Birth Hospital**

Guarantor Information (Person financially responsible)

Name	Relationship to Patient		Emancipated Minor? ☐ Yes ☐ No
Street Address (If different from patient)	City	State	Zip
Date of Birth	Home #	Work #	Cell #
Employer Name	City	State	Zip

Insurance Information (if insurance is provided, please complete the information below)

Insurance Name	Claims Address	Telephone #

Subscriber ID #	Group #	Patient Relationship to Subscriber:
Subscriber's Name		DOB:
Subscriber Address (if different than guarantor)		Subscriber Employer