

Grove Pediatrics & Adolescent Medicine

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New Patient Registration Form

Please complete all sections. This information helps us provide the best care for your child.

Registering more than one child? Complete one section per child (Patients 1–4) below.

Patient 1 Information

Patient Full Name:

Date of Birth:

Sex:

Preferred Name:

Race (check all that apply):

- ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White
☐ Native Hawaiian or Other Pacific Islander ☐ Other: _____ ☐ Prefer not to answer

Home Address:

City / State / ZIP:

Patient 2 Information (if applicable — same address as Patient 1)

Patient Full Name:

Date of Birth:

Sex:

Preferred Name:

Race (check all that apply):

- ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White
☐ Native Hawaiian or Other Pacific Islander ☐ Other: _____ ☐ Prefer not to answer

Patient 3 Information (if applicable — same address as Patient 1)

Patient Full Name:

Date of Birth:

Sex:

Preferred Name:

Race (check all that apply):

- ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White
☐ Native Hawaiian or Other Pacific Islander ☐ Other: _____ ☐ Prefer not to answer

Patient 4 Information (if applicable — same address as Patient 1)

Patient Full Name:

Date of Birth:

Sex:

Preferred Name:

Race (check all that apply):

- ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White
☐ Native Hawaiian or Other Pacific Islander ☐ Other: _____ ☐ Prefer not to answer

Parent / Guardian #1

Full Name:

Relationship to Patient(s):

Home Phone:

Cell Phone:

Email Address:

Employer:

Parent / Guardian #2 (if applicable)

Full Name:

Relationship to Patient(s):

Home Phone:

Cell Phone:

Email Address:

Employer:

Emergency Contact (if different from above)

Full Name:

Relationship:

Phone:

Preferred Pharmacy

Pharmacy Name:

Phone:

Address:

Insurance Information — Primary

Insurance Company:

Subscriber Name:

Policy / Member ID #:

Group #:

Subscriber Date of Birth:

Relationship to Patient(s):

Insurance Information — Secondary (if applicable)

Insurance Company:

Subscriber Name:

Policy / Member ID #:

Group #:

How did you hear about our practice?

☐ Friend/Family Referral ☐ Physician Referral ☐ Insurance Directory ☐ Online Search ☐ Other

Signature (Parent/Guardian):

Date:

Printed Name:

Relationship to Patient(s):
