UCSF Benioff Children's Physicians

Pediatric Patient Registration Form

*Instructions: Please complete **all applicable fields** below.*

Patient Information		
Patient Name (Last, First):		
Date of Birth (DOB):	Sex:	SSN:
(2) Child Name (Last, First):		
DOB:	Sex:	SSN:
(3) Child Name (Last, First):		
DOB:	Sex:	SSN:

Home Address:	
Home Phone #:	**Email Address:**
What is the family's preferred language?	**Would you like an interpreter**? ☐ Yes ☐ No
How would you like to receive appointment reminders? ☐ Text Message ☐ Phone Call ☐ Do Not Remind	Is the **patient** employed? ☐ Yes ☐ No If yes**, Employer Name**: **Employment Status:** ☐ Full Time ☐ Part Time
Name of Pediatrician:	

Patient Contacts	
In **case of an emergency**, please provide the **names of individuals** (e.g. parent or grandparent) we should contact below:	
(1) Patient Contact Name:	
Is this emergency contact's address **the same** as the patient's address? ☐ Yes ☐ No	
*If no, please **enter address** here:*	
Is this person a **parent/legal guardian** of the patient? ☐ Yes ☐ No	
Home and/or Cell Phone #:	**Relationship to Patient:** ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Aunt/Uncle ☐ Grandparent ☐ Other Relative ☐ Neighbor ☐ Caregiver
(2) Patient Contact Name:	
Is this emergency contact's address **the same** as the patient's address? ☐ Yes ☐ No	
*If no, please **enter address** here:*	
Is this person a **parent/legal guardian** of the patient? ☐ Yes ☐ No	
Home and/or Cell Phone #:	**Relationship to Patient:** ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Aunt/Uncle ☐ Grandparent ☐ Other Relative ☐ Neighbor ☐ Caregiver

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Guarantor Information

Who is **financially responsible** for the patient's account if there are costs **not covered** by the health insurance plan?

☐ (1) Patient Contact ☐ (2) Patient Contact ☐ Someone Else

If 'Someone Else' please provide their **name and address**:

Guarantor's Sex:	**SSN:**	**DOB:**

Relationship to Patient: ☐ Parent/Legal Guardian ☐ Foster Parent ☐ Grandparent ☐ Other Relative

Email Address:

Is this person **currently employed**? ☐ Yes ☐ No

If yes, complete below:

Employer Name:	☐ Full Time ☐ Part Time ☐ Retired

Primary Insurance Information

Name of primary health insurance coverage plan:

Policy ID #:	**Group #:**

Who is the primary subscriber of the plan?

☐ (1) Patient Contact ☐ (2) Patient Contact ☐ Guarantor ☐ Patient *(only select if patient has a Medi-Cal or Medi-Cal HMO plan)*

Secondary Insurance Information

Name of secondary health insurance coverage plan:

Policy ID #:	**Group #:**

Who is the primary subscriber of the secondary plan?

☐ (1) Patient Contact ☐ (2) Patient Contact ☐ Guarantor ☐ Patient *(only select if patient has a Medi-Cal or Medi-Cal HMO plan)*

How Did You Hear About Us?

☐ Family/Friend ☐ Referring Provider ☐ Internet/TV/Radio ☐ Health Insurance Provider ☐ Not Sure

Name of Referring Provider:

What is the Name and Address of Your Preferred Pharmacy?

Parent/Legal Guardian Signature:	**Today's Date:**

Thank You! Please hand this form back to the registration staff at the front desk.