Delaware Pediatrics, P.A.
Where futures grow

Delaware Pediatrics
Patient Registration (Over 18)

First Name: _____ Last Name_____ MI. _____
DOB: _____/_____/_____ Sex: _____ Primary Language: _____
Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White

Primary Phone: (_____) _____
Cell Phone: (_____) _____ Work Phone: (_____) _____
Home Email: _____ Work Email: _____
Employer: _____ Occupation: _____

Mailing Address: _____
(Street or PO Box) (City) (State & Zip)

Who lives at this household? _____

How would you ideally prefer to be contacted regarding: **(circle one option per line)**
Medical issues: Home Ph / Work Ph / Cell Ph / Text / Home Email / Work Email / Mail Addr
Appointment Reminders: Home Ph / Work Ph / Cell Ph / Text / Home Email / Work Email / Mail Addr
Recall Notices: Home Ph / Work Ph / Cell Ph / Text / Home Email / Work Email / Mail Addr
Billing Statements: Home Address (ONL Y OPTION)
General Practice Notices: Home Ph / Work Ph / Cell Ph / Text / Home Email / Work Email / Mail Addr
Patient Portal Notifications: Home Email (ONLY OPTION)

Emergency Contacts:
1: _____ Relationship: _____ Phone: (____) _____-_____
2: _____ Relationship: _____ Phone: (____) _____-_____
3: _____ Relationship: _____ Phone: (____) _____-_____

Additional Contact Questions:
Who should receive billing statements? _____
May all contacts have access to the patient's records electronically? Yes / No **(circle one)**

Insurance:
Primary Insurance: Policy Holder's Name: _____
Policy Holder's Date of Birth: _____/_____/_____ Policy Holder's Sex: Male/Female
Insurance Carrier: _____
ID #: _____ Group # _____
Secondary Insurance: Policy Holder's Name: _____
Policy Holder's Date of Birth: _____/_____/_____ Policy Holder's Sex: Male/Female
Insurance Carrier: _____
ID #: _____ Group # _____

I authorize the release of any medical information necessary to process health insurance claims. A copy of this form can be considered as an original for insurance purposes. I authorize payment of medical benefits to Delaware Pediatrics, P.A. I acknowledge that at least 24 hours' notice is required for cancellation of an office visit and at least 2 hours' notice is required for the cancellation of a sick visit. Failing to do so may result in a "no show" fee of 35$ for each missed visit. Three or more missed visits (per family) will result in a warning letter mailed to home. Subsequent missed visits after a warning letter has been received may result in discharge from the practice due to non-compliance.

Printed Name: _____ Signature: _____ Date: _____