BRIGHTON HILL PEDIATRICS REGISTRATION FORM **PLEASE FILL OUT FRONT & BACK** 1/2015

Date: _____Child's Dr. /N.P. _____Referred By: _____

Patient/Children's First & Last Name(s)	**DOB**	**Gender M/F**	**Lives with Mother/Father/Both**
1.			
2.			
3.			
4.			

PLEASE CIRCLE OR FILL IN THE REQUIRED STATE AND FEDERAL REGULATIONS Brighton Hill Pediatrics must be in compliance with

1. Ethnicity: Hispanic Latino Neither **2. Language: _____**

3. Race: Native American Asian Black African American Native Hawaiian White

Mother's Maiden Name _____New York State Law **REQUIRES** this information for the Immunization Registry.

Primary Parent/Guardian: Name _____DOB_____SEX: M F SS#_____

Address_____City_____State_____Zip _____

Home Phone # _____Cell Phone # _____Other #_____

Employer _____Occupation _____Work # _____

Parent/Guardian/Step: Name_____ DOB _____SEX: M F SS#_____

Address_____City_____State_____Zip_____

Home Phone #_____Cell Phone # _____Other #_____

Employer _____Occupation _____Work #_____

E-MAIL Address_____ Receive E-Mail Newsletter Y_____ N_____

Pharmacy of Choice_____

BILLING INFORMATION (PLEASE COMPLETE THIS ENTIRE SECTION, INCLUDING POLICY ID'S)

RESPONSIBLE PARTY FOR BILLS (name/address):_____

Primary Insurance Company _____**Policy/ID #**_____

Subscriber's First & Last Name _____DOB_____

Secondary Insurance Company _____**Policy/ID #** _____

Subscriber's First & Last Name _____DOB_____

EMERGENCY CONTACTS (other than a parent or guardian) **Name(s), Phone Number(s) and Relationship**_____

_____

Does your home have well water? _____ Year that your home was built? _____