NEMOURS REGISTRATION FORM

Date *(mm/dd/yy)*: ____________________

Time: ____________________

Check one: ☐ a.m. ☐ p.m.

Patient Information

Name (First, Last and M.I.): ____________________ ____________________ ________

Social Security number: ____________________

Sex: ☐ Male ☐ Female Date of birth: ____________________ Alias: ____________________

Address: ____________________

City: ____________________ State: ________ Zip code: ________ County: ____________

Please check box for primary phone number. *(The number that should be called first)*

☐ Home telephone number: ____________________ ☐ Mom's mobile number: ____________________

☐ Dad's mobile number: ____________________ ☐ Other number: ____________________

Comments: ____________________

Email address: ____________________

My Nemours: ☐ Yes ☐ No

Reason for no email: Declined: ________ ____________________

None: ____________________

Language (Check one): ☐ English ☐ Spanish ☐ Sign ☐ French ☐ Other____________________

Speak English? *(Answer if patient is over 5 years old)* ☐ Not at all ☐ Not well ☐ Well ☐ Very well ☐ Refused

Interpreter Needed *(Check one)*: ☐ Yes ☐ No

Religion: ____________________

Ethnicity *(Check one)*: ☐ Cuban ☐ Puerto Rican ☐ Mexican, Mexican American, Chicano/a ☐ Another Hispanic, Latino, or Spanish Origin ☐ Non Hispanic or Latino ☐ Refused

Race *(Check one)*: ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese
☐ Guamanian or Chamorro ☐ Korean ☐ Other Asian ☐ Samoan ☐ Some other Race
☐ Vietnamese ☐ Black or African-American ☐ White or Caucasian
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other ☐ Refused

Primary Care Physician/Provider – Only Complete when PCP is not a Nemours Provider

Physician name: ____________________ Telephone number: ____________________

Name of practice: ____________________

Address: ____________________

City: ____________________ State: ________ Zip code: ____________________

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Patient name: ____________________

Mother

Name: ____________________ Date of birth: ____________

☐ Hearing impaired ☐ Visually impaired

Telephone number: ____________ Work number: ____________ Mobile number: ____________

Address: ____________________ City: ____________ State: ______ Zip code: ______

Do you have legal custody of the patient *(Check one)?* ☐ Full custody ☐ Shared custody ☐ Does not have custody

Father

Name: ____________________ Date of birth: ____________

☐ Hearing impaired ☐ Visually impaired

Telephone number: ____________ Work number: ____________ Mobile number: ____________

Address: ____________________ City: ____________ State: ______ Zip code: ______

Do you have legal custody of the patient *(Check one)?* ☐ Full custody ☐ Shared custody ☐ Does not have custody

Legal Guardian

Name: ____________________ Date of birth: ____________

☐ Hearing impaired ☐ Visually impaired

Telephone number: ____________ Work number: ____________ Mobile number: ____________

Address: ____________________ City: ____________ State: ______ Zip code: ______

Do you have legal custody of the patient *(Check one)?* ☐ Full custody ☐ Shared custody ☐ Does not have custody

Emergency Contacts

Emergency Contact 1 *(outside of home)*

Name: ____________________ Telephone number: ____________

Address: ____________________ City: ____________ State: ______ Zip code: ______

Telephone number: __________ Work number: __________ Mobile number: __________ Relationship: __________

Emergency Contact 2 *(outside of home)*

Name: ____________________ Telephone number: ____________

Address: ____________________ City: ____________ State: ______ Zip code: ______

Telephone number: __________ Work number: __________ Mobile number: __________ Relationship: __________

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Patient name: ____________________

Pharmacy

Name of pharmacy: ____________________ Phone number: ____________________

Cross streets: ____________________

City: ____________________ State: __________ ☐ No pharmacy

Guarantor Information *(person financially responsible for services provided)*

Name: ____________________

Relationship: __________ Home telephone number: ____________________ Work number: ____________________

Address: ____________________ City: ____________________ State: ________ Zip code: __________

Sex: __________ Date of birth: ____________________ Social Security number: ____________________

Employer's name: ____________________ Employer's address: ____________________

City: ____________________ State: __________ Zip code: __________

☐ Full time ☐ Part time ☐ Student part time ☐ Student full time ☐ Unemployed ☐ Retired

Guarantor language: ____________________ How did you hear about us? ____________________

Primary Insurance Information

Name of insurance company: ____________________ Telephone number: ____________________

Claims address: ____________________ City: ____________________ State: ______ Zip code: __________

Effective date: ____________________ Expiration date: ____________________ Group name: ____________________

Policy number: ____________________ Group number: ____________________ Co-Pay: ____________________

If visit is due to an accident, accident date: ____________________

Subscriber's name: ____________________

Subscriber's date of birth: ____________________ Relationship of subscriber to patient: ____________________

Name of subscriber's employer: ____________________ Occupation: ____________________

Employer's address: ____________________

City: ____________________ State: ______ Zip code: __________

Subscriber's work telephone number: ____________________ Employment status: ____________________

Subscriber's Social Security number: ____________________

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Patient name: ______________________________

Other or Secondary Insurance Information (if applicable)

Name of insurance company: ______________________ Telephone number: ______________

Claims address: ______________ City: ______________ State: _______ Zip code: ______________

Effective date: ______________ Expiration date: ______________ Group name: ______________

Policy number: ______________ Group number: ______________ Co-Pay: ______________

If visit is due to an accident, accident date: ______________

Subscriber's name: ______________________________

Subscriber's date of birth: ______________ Relationship of subscriber to patient: ______________

Name of subscriber's employer: ______________ Occupation: ______________

Employer's address: ______________________________

City: ______________________ State: _______ Zip code: ______________

Subscriber's work telephone number: ______________ Employment status: ______________

Subscriber's Social Security number: ______________________________

Siblings

Name: ______________________________ Date of birth: ______________

Insurance Name: ______________________ Insurance ID: ______________

Name: ______________________________ Date of birth: ______________

Insurance Name: ______________________ Insurance ID: ______________

Name: ______________________________ Date of birth: ______________

Insurance Name: ______________________ Insurance ID: ______________

Is Guarantor and Contact information the same for all siblings? ☐ Yes ☐ No (*If no, please use additional registration form to provide information.)*

SIGNATURE

Parent/Guardian/Other: ______________________________

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