



Hendricks Regional Health Medical Group
Pediatric Patient Registration

Please Print Clearly

Date _____

Physician _____

Patient Information

Name _____

Address _____

City _____

State _____ Zip Code _____

Home Phone _____

Parent Phone Number (cell) _____

Parent Phone Number (work) _____

Date of Birth _____ Male Female

Single Married SSN _____

Emergency Contact _____
(not living with you)

Emergency Contact phone _____

Relationship to Emergency Contact _____

PCP _____

Referred By if other than PCP _____

Primary Insurance _____

Secondary Insurance _____

Local Pharmacy _____

Mail In Pharmacy _____

Responsible Party (person who will receive statements)

Name _____

Address _____

City _____

State _____ Zip Code _____

Parent Information

Mother's Name _____

Address _____
(If different from patient)

Father's Name _____

Address _____
(If different from patient)

Custodial Parent if Divorced _____

Insured Information

Primary Ins: Insured Name _____

Date of Birth _____ SSN _____

Relationship to patient _____

Secondary Ins: Insured Name _____

Date of Birth _____ SSN _____

Relationship to patient _____

I authorize the physicians and staff of Hendricks Regional Health Medical Group to leave detailed information regarding follow up appointments, test results or other routine medical care on voicemail at the following phone number
(____) _____

Parent/Guardian Signature