Patient Registration Form

COBB PEDIATRIC ASSOCIATES, P.C.

PATIENT'S NAME: _____

(Parents)	*Mother/Parent 1*	*Father/Parent 2*
Full Name		
Date of Birth		
Marital Status		
Home Address, Street		
City, State, Zip		
Home or Primary Phone		
Cell Phone No.		
Work Phone No.		
E-mail Address		
Employer Name		
Employer Address, Street		
City, State, Zip		
Nearest Relative and Phone No. (home & cell)		

Child's Information		*Pharmacy Information*	
Date of Birth		**Pharmacy Name**	
Gender		**Address, Street**	
Race		**City, State, Zip**	
Ethnicity		**Phone No.**	
Preferred Language			
Name *all siblings seen by us*			

INSURANCE	*Primary*	*Secondary*
Subscriber		
Company		
Address **City, State, Zip**		
Policy Number		
Group Number		

***Please let us know who referred you to our office, as we would like to say thank you*. _____**

_____

I, _____, have received a copy of Cobb Pediatric Associates, P.C.'s Notice of Privacy Practices, Financial Policy, Appointment Cancellation Policy and the Statement Regarding Cobb Pediatric Associates' Use of Nurse Practitioners as Medical Providers in the Practice. ***I understand that I have the right to refuse to complete and to sign this form; however, by doing so, I am required to pay for services to Cobb Pediatric Associates, PC, in full, at the time of service.***

***Signature:** _____ **Date:** _____

(Guarantor)