

**REGISTRATION RECORD**

**Child's Name:** \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female  
First Middle Last

Address: \_\_\_\_\_ Home # \_\_\_\_\_

City, State & Zip: \_\_\_\_\_ Cell # \_\_\_\_\_

Email Address: \_\_\_\_\_ Emergency Contact \_\_\_\_\_

Delivery Hospital: \_\_\_\_\_ Emergency phone# \_\_\_\_\_

<p><input type="checkbox"/> <b>Mother</b>   <input type="checkbox"/> <b>Stepmother</b>   <input type="checkbox"/> <b>Guardian</b></p> <p>Name: _____</p> <p>Address: _____</p> <p>City, State &amp; Zip: _____</p> <p>Birth Date ____/____/____ SS# _____</p> <p>Home #: _____ Work #: _____</p> <p>Employer Name _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p>	<p><input type="checkbox"/> <b>Father</b>   <input type="checkbox"/> <b>Stepfather</b>   <input type="checkbox"/> <b>Guardian</b></p> <p>Name: _____</p> <p>Address: _____</p> <p>City, State &amp; Zip: _____</p> <p>Birth Date ____/____/____ SS# _____</p> <p>Home #: _____ Work #: _____</p> <p>Employer Name _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p>
<p>Parents Marital Status:   <input type="checkbox"/> Married   <input type="checkbox"/> Divorced   <input type="checkbox"/> Single   <input type="checkbox"/> Separated   <input type="checkbox"/> Widowed</p>	

<p><b>Primary Insurance</b></p>	<p><b>Secondary Insurance</b></p>
<p>Policy Holder's name: _____</p> <p>Relationship to patient: _____</p> <p>Employer: _____</p> <p>Address: _____</p> <p>Insurance Co: _____</p> <p>Policy ID#: _____ Group#: _____</p>	<p>Policy Holder's name: _____</p> <p>Relationship to patient: _____</p> <p>Employer: _____</p> <p>Address: _____</p> <p>Insurance Co: _____</p> <p>Policy ID#: _____ Group#: _____</p>
<p>Who referred you to Galloway Pediatrics, LLC? _____</p>	

**Pharmacy Name:** \_\_\_\_\_ **Phone #** \_\_\_\_\_

I authorize Galloway Pediatrics, LLC to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of care to third party payers and/or other health practitioners. I authorized and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I realize that I will be held responsible for all cost of collection of this account which may include additional fees.

\_\_\_\_\_  
Signature of Patient or Parent/Guardian if Minor

\_\_\_\_\_  
Date