

**Community Care Pediatrics-Saratoga  
REGISTRATION RECORD**

(Please Print)



Today's date:					
PATIENT INFORMATION					
Patient's last name:		First:	Middle:	Birth date: / /	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
Street address:				Home Phone no.: ( )	
P.O. Box:	City:		State:	ZIP Code:	
Cell Phone no.:	E-mail address:			Delivery Hospital: ( )	
How did you learn about our office?			<input type="checkbox"/> Another Doctor	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other:	

PRIMARY INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Policy Holder's Name:					
Effective Date: / /	Group no.:		Policy no.:	Co-payment: \$	
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
Policy no.:			Group no.:		

IN CASE OF EMERGENCY					
Name of Emergency Contact:			Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
MOTHER		STEPMOTHER		GUARDIAN	
Name:			Birth date: / /		
Street Address:				P.O. Box:	
City:	State:	Zip:	Home Phone no.: ( )	Cell Phone no.: ( )	Work Phone no.: ( )
Employer Name and Address:					
FATHER		STEPFATHER		GUARDIAN	
Name:			Birth date: / /		
Street Address:				P.O. Box:	
City:	State:	Zip:	Home Phone no.: ( )	Cell Phone no.: ( )	Work Phone no.: ( )
Employer Name and Address:					