Tiger Pediatrics
4741 Hwy 153 Suite A, Easley, SC 29642 Phone: 864.661.5278 Fax: 864-408-8369

Registration Form

Child 1: Last Name:_____First Name:_____MI: ___

DOB:____/___/_____ Sex: M / F Preferred Language: _____

Race: □African American □Asian □White□Other □Decline

Ethnicity: □Hispanic/Latino □ Non-Hispanic/Latino □Unknown □Decline

Child 2: Last Name:_____First Name:_____MI: ___

DOB:____/___/_____ Sex: M / F Preferred Language: _____

Race: □African American □Asian □White□Other □Decline

Ethnicity: □Hispanic/Latino □ Non-Hispanic/Latino □Unknown □Decline

Child 3: Last Name:_____First Name:_____MI: ___

DOB:____/___/_____ Sex: M / F Preferred Language: _____

Race: □African American □Asian □White□Other □Decline

Ethnicity: □Hispanic/Latino □ Non-Hispanic/Latino □Unknown □Decline

Parent/Legal Guardian 1:

Child(ren)'s parents are: □Married □Divorced □Never Married □Separated □Widow(er) □Other

Name:_____Relationship to Patient: _____

DOB:____/___/_____Home phone: _____Cell phone: _____

Address: _____

Email: _____

Employer:_____Occupation: _____

Lives with patient? □Yes □No

Parent/Legal Guardian 2:

Child(ren)'s parents are: □Married □Divorced □Never Married □Separated □Widow(er) □Other

Name:_____Relationship to Patient: _____

DOB:____/___/_____Home phone: _____Cell phone: _____

Address: _____

Email: _____

Employer:_____Occupation: _____

Lives with patient? □Yes □No

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Emergency Contacts, other than parents. Name/Relationship:

Name:_____Phone: _____

Name:_____Phone: _____

Insurance Information

Primary Insurance Carrier: _____

Policy Holder Name: _____

Group No: _____ Member No: _____

Secondary Insurance Carrier: _____

Policy Holder Name: _____

Group No: _____ Member No: _____

Additional Questions:

Who should receive billing statements? _____

If parents are divorced, separated or unmarried, please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? □Yes □No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

Our office follows the American Academy of Pediatrics vaccine guidelines. We do not accommodate alternate vaccine schedules. Do you plan to follow the required vaccine schedule? □Yes □ No

How did you hear about our office (friend, Google, Facebook, etc)? _____