Aloha Pediatrics

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Registration form

Patient's name: _____ Sex: □ M □ F DOB: ___/___/____

Sibling 1: _____ Sex: □ M □ F DOB: ___/___/____

Sibling 2: _____ Sex: □ M □ F DOB: ___/___/____

Sibling 3: _____ Sex: □ M □ F DOB: ___/___/____

Mother's Name: _____ DOB: ___/___/____ Email: _____

Home Phone: _____ Mobile: _____ Work: _____

Father's Name: _____ DOB: __/ __/____ Email: _____

Home Phone: _____ Mobile: _____ Work: _____

Mailing Address: _____

Street or P.O. Box City State Zip

Insurance: _____ Ins ID#: _____ Subscriber name: _____

Emergency Contact (other than parent): _____ Phone: _____

Is anyone else (other than parent) allowed to bring the child in? Yes No (Circle one)

Name: _____ Relation: _____

If your child is over 15, are they allowed to come by themselves? Yes No (Circle one)

May we sign you up on the patient portal? Yes No (Circle one)

By signing and dating below you are certifying that all of the above information is true and correct.

_____ _____

Printed Name Signature

_____ _____

Relation to patient Date