

Name: _____ DOB: _____
Chart: _____ Date: _____
Age: _____

Sandhills Pediatrics; 195 West Illinois Ave; Southern Pines, NC 28387 Phone 910-692-2444

Patient Registration Form

*** REQUIRED FIELDS**

First Name _____ MI _____ Date of Birth _____

Last Name _____ Social Sec # _____ Age _____

Gender (circle one): Boy Girl Ethnic Group (circle one): Non Hispanic, non-Latino OR Hispanic or Latino
Race (circle one): American Indian/Alaskan Native; Asian; Black or African American;
Native Hawaiian or Pacific Islander; White; Other

Provider Preference (circle one): Sherrington, Stewart, Boals, Diasio, Mason, Carlton, Locklear,
Clarke-Pearson, Andrews, Ivey, Brantley, H. Mabry, J. Mabry

Home Address(mailing) _____

Home Address(physical) _____

Family Email _____ Phone # : Home (_____) _____

Parent/Guardian Info

Mom-Last Name _____ First Name _____ MI _____

Mom's Maiden Name _____ Date of Birth* _____ Social Sec # _____

Mailing address of **RESPONSIBLE PARTY**, if different from above:*

Work (_____) Cell (_____) _____

Dad-Last Name _____ First Name _____ MI _____

Date of Birth * _____ Social Sec # _____

(Date of birth of parents required for insurance billing due to federal rules)

Do you have any children that were seen by one of our doctors at this office or Moore Regional Hospital prior to today's visit?

Yes	No	Name _____	DOB _____
		Name _____	DOB _____
		Name _____	DOB _____
		Name _____	DOB _____

Insurance Info

Primary Insurance Name * _____ Policy # * _____

Group # * _____

Employer Name of Person Who Has Insurance _____

Secondary Insurance Name * _____ Policy # * _____

Group # * _____

Name of Employee Who Has Insurance * _____

Emergency Contact

Contact Name: _____ Relationship to Patient: _____

Home Phone (_____) _____ Work Phone (_____) _____

Do we have permission to contact them in an emergency and leave messages if necessary? Yes _____ No _____

Signature * _____ Date _____