Royal
KIDS
Pediatric Clinic

PATIENT REGISTRATION / INFORMATION SHEET

PATIENT INFORMATION

NAME: _____

LAST MIDDLE FIRST

Date of Birth: _____
Gender: Male Female
Last four digits of Social Security Number: __ __ __ __

Street Address: _____
Sibling Name: _____
Sibling Name: _____
Sibling Name: _____
Sibling Name: _____
Mobile Number if child is >14 years

If children have different addresses, different parents, or a different person carries insurance, please complete a separate form for each.

Patient is living with: (circle one)
Both Parents Father Mother Parent and Step Parent Other

PARENT/GUARDIAN INFORMATION

___Preferred Emergency Contact

Name:

_____
LAST MIDDLE FIRST
Home Phone: _____
Street Address: IF DIFFERENT THAN PATIENT:
_____ City: _____ State: _____ Zip: _____

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Last Four Digits of Social Security Number: __ __ __ __

Date of Birth:_____Home Phone:_____

Marital Status: Single Married Divorced Widowed

Employer: _____

Street Address: _____

City: _____ State: ____ Zip: _____

Office Phone Number: _____

Relationship to Patient: _____
EmailAddress*:_____

Cell Phone: _____

Occupation: _____

**By providing your email address, you are electing to receive email communication from ROYALKIDS CLINIC*

PARENT/GUARDIAN INFORMATION

___Preferred Emergency Contact

Name:

_____
LAST MIDDLE FIRST
Home Phone: _____
Street Address:IF DIFFERENT THAN PATIENT : _____State_____
City: _____ Zip: _____

Last Four digits of Social Security Number: __ __ __ __

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Date of Birth:_____ Home Phone: _____

Marital Status: Single Married Divorced Widowed

Employer: _____

Street Address: _____

City: _____ State: ___ Zip: _____

Office Phone Number: _____

Relationship to Patient: _____
EmailAddress*:_____

Cell Phone: _____

Occupation: _____

**By providing your email address, you are electing to receive email communication from ROYALKIDS CLINIC*

ADDITIONAL EMERGENCY CONTACT (OTHER THAN PARENT/ GUARDIAN)

Name: _____

Cell Phone: _____

Relationship to Patient: _____

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INSURANCE INFORMATION

To whom should the billing statement be mailed?
_____

Primary Insurance: HMO PPO MediCal Cash Other:_____
Insurance Company Name: _____
Group #: _____
Policy/ID#: _____
Primary Insurance Subscriber: _____
Relationship to Patient: _____
Date of Birth:_____
Last Four Digits of Social Security Number:__ __ __ __
Secondary Insurance: HMO PPO MediCal Cash Other:_____
Insurance Company Name: _____
Group #: _____
Policy/ID#: _____
Primary Insurance Subscriber: _____
Relationship to Patient: _____
Date of Birth:_____
Last Four Digits of Social Security Number:__ __ __ __

ADDITIONAL PATIENT INFORMATION (OPTIONAL)

Race: American Indian White Asian African American Native Hawaiian Other Unknown
Ethnicity: Hispanic/Latino Non-Hispanic/Latino
Language: English Other
Who referred you to us_____

Parent/Guardian Signature: _____
Date/Time: _____