Associated Urologists of NC, PA

New Pediatric Registration

MRN: _____

Patient Information

Child's First Name	Child's Last Name	Child's MI	Child's DOB

Mailing Address	City	State	Zip

Street Address	City	State	Zip

Place an ☒ for preferred number for electronically generated calls	❑ Home Phone	❑ Work Phone	❑ Cell Phone

Other Name(s) Used	Email Address

Gender ❑ Male ❑ Female	Social Security Number _____ - _____ - _____	Preferred Language	Do you need an interpreter? ❑ Yes ❑ No

Preferred Contact		**Ethinicity**	**Race**	
❑ Cell Phone ❑ Home Phone ❑ Work Phone	❑ Email ❑ Patient Portal	❑ Hispanic/Latino ❑ Non-Hispanic	❑ Native Indian or Alaskan Native ❑ Asian ❑ Black or African American	❑ Native Hawaiian or Pacific Islander ❑ White ❑ Other:

Hospital where child was born:	Does the patient live in a Group Home or Foster Care? ❑ No ❑ Yes: (If yes, please list)

Mother

First Name	Last Name	MI	Date of Birth	Social Security Number _____ - _____ - _____

Mailing Address	City	State	Zip

Place an ☒ for preferred number for electronically generated calls	❑ Home Phone	❑ Work Phone	❑ Cell Phone	Marital Status ❑ M ❑ S ❑ W ❑ D

Other Name(s) Used	Email address

Employer Name	Employer Address	Employer Phone

Father

First Name	Last Name	MI	Date of Birth	Social Security Number _____ - _____ - _____

Mailing Address	City	State	Zip

Place an ☒ for preferred number for electronically generated calls	❑ Home Phone	❑ Work Phone	❑ Cell Phone	Marital Status ❑ M ❑ S ❑ W ❑ D

Other Name(s) Used	Email address

Employer Name	Employer Address	Employer Phone

Emergency Contact

First Name	Last Name	MI	Date of Birth

Relationship to Patient	❑ Home Phone	❑ Work Phone	❑ Cell Phone

Primary Medical Insurance	**Secondary Medical Insurance**
Insurance Company Name	Insurance Company Name
Policy Holder Name DOB	Policy Holder Name DOB
Policy Number	Policy Number
Group Number (if applicable)	Group Number (if applicable)

Primary Care Provider	**Primary Pharmacy**
Name:	Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Phone:	Phone:
Fax:	Fax:

Signature: _____ **Relationship to Patient** _____ **Date:** _____