Dr.Miniyar's Pediatrics, P.C.

Registration Form

Patient Information:

Child's First Name_____ Last_____

Goes by:_____ Date of Birth _____ Gender: M / F

Address:_____ City_____Zip_____

Patient Lives With: Both Parents / Mother / Father / Grandparent (s) / Foster care /_____

Primary Parent / Guardian:

Relationship to patient _____

First Name_____ Last Name_____DOB_____

Cell Phone_____Emergency Contact number_____

Email (required)_____ SS#_____

Secondary Parent / Guardian:

Relationship to patient _____

First Name_____ Last Name_____DOB_____

Cell Phone_____Emergency Contact number_____

Email (required)_____ SS#_____

Additional People Authorized:

I give my permission to the following people to seek medical care/ advice for my child in person or over phone and have full access to my child's medical record.

Full Name_____ Relationship_____Ph_____

Full Name_____ Relationship_____Ph_____

Full Name_____ Relationship_____Ph_____

Medicaid Information: **a) Do you have: PEACHCARE OR STRAIGHT MEDICIAD**

b) Which CMO do you have: Amerigroup / Caresource / Peachstate

Medicaid Number:_____ Amerigroup/Caresource/Peachstate #_____

Primary Private Insurance Name (Please give the card) : _____

Secondary Private Insurance Name (Please give the card) : _____

PLEASE GIVE DRIVER'S LICENSE FOR **EACH** PARENT (MOM & DAD) & INSURANCE CARD FOR **EACH** INSURANCE YOU HAVE TO FRONT . THIS IS VERY IMPORTANT.

Parent's Signature_____ Date_____