Margiotti & Kroll
PEDIATRICS, P.C.

Patient Registration Forms

In order to serve you, we need the following information. Please print.

Today's Date:	Preferred Office: ☐ Trevose ☐ Newtown ☐ Valley Square ☐ Northeast ☐ Oxford Valley

PATIENT INFORMATION

Patient's Last Name:	First Name:	Middle:	Nickname:
Date of Birth:	Age:	Gender:	Student: ☐ Part Time ☐ Full Time
Patient's Address:	Apt:	City/Town:	State:	Zip Code:
Primary Phone:	Daytime (Work) Phone:	Mobile (Cell) Phone:	
Patient E-Mail Address: (if applicable)	Emergency Contact:		
Preferred Language:	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer		

Race: ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Decline to Answer

Preferred M&K Pediatrics Physician/Clinician:

Preferred Contact Method: (select one for each **if patient is over 18**) ☐ No Contact (*contact guardian*)

Medical Issues/Problems:			☐ Cell Phone	☐ Home Phone	☐ No Contact (*contact guardian*)
Appointment Reminders:	☐ Text to Cell	☐ E-Mail			☐ No Contact (*contact guardian*)
Due for Visit:	☐ Text to Cell	☐ E-Mail	☐ Cell Phone	☐ Home Phone	☐ No Contact (*contact guardian*)

Hospital:	Obstetrician:	Referred By:

PHARMACY INFORMATION

Name of Pharmacy:	Address:	Phone:
		Fax:

PARENT/GUARDIAN #1 INFORMATION

(This parent/guardian will be listed as the primary contact for the patient listed above)

Parent/Guardian's Last Name:	First Name:	Middle:	Nickname:
SSN:	Date of Birth:	Relation to Patient:	☐ Check here if patient is the genetic child of this parent ☐ Check here if patient lives with this parent/guardian?
Address: (Leave blank if same as patient)	Apt:	City/Town:	State:	Zip Code:
Primary Phone:	Daytime (Work) Phone:	Mobile (Cell) Phone:	
Preferred Language:	Parent/Guardian Home E-Mail Address:		
Employer:	Occupation:		

Preferred Contact Method: (select one for each)

Medical Issues/Problems:			☐ Cell Phone	☐ Home Phone
Appointment Reminders:	☐ Text to Cell	☐ E-Mail		
Due for Visit:	☐ Text to Cell	☐ E-Mail	☐ Cell Phone	☐ Home Phone

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PARENT/GUARDIAN #2 INFORMATION

(This parent/guardian will be listed as the secondary contact for the patient listed above)

☐ Check here if patient does not have a secondary parent/guardian. (If selected please skip this section)

Parent/Guardian's Last Name:	First Name:	Middle:	Nickname:

SSN:	Date of Birth:	Relation to Patient:	☐ Check here if patient is the genetic child of this parent ☐ Check here if patient lives with this parent/guardian?

Address: (Leave blank if same as patient)	Apt:	City/Town:	State:	Zip Code:

Primary (Home) Phone:	Daytime (Work) Phone:	Mobile (Cell) Phone:

Preferred Language:	Parent/Guardian Home E-Mail Address:
Employer:	Occupation:

Preferred Contact Method: (select one for each) *Only used if primary parent/guardian is unable to be reached unless otherwise specified*

Medical Issues/Problems: ☐ Cell Phone ☐ Home Phone

Appointment Reminders: ☐ Text to Cell ☐ E-Mail

Due for Visit: ☐ Text to Cell ☐ E-Mail ☐ Cell Phone ☐ Home Phone

AUTHORIZED FAMILY MEMBER / CARETAKER INFORMATION

(Persons listed in this section are permitted to accompany and consent to the examination and/or treatment of the patient listed above until expressly revoked by a parent/guardian)

☐ Check here if you do not authorize any additional family members/caretakers to accompany and consent to the examination and/or treatment of this patient in the absence of a parent/guardian. (If selected please skip the next section)

1st Authorized Party Last Name:	First Name:	Relation to Patient:
Phone Number:	This authorization is effective from _____________ through_____________. This authorization is effective from _____________ until revoked by me in writing.	
2nd Authorized Party Last Name:	First Name:	Relation to Patient:
Phone Number:	This authorization is effective from _____________ through_____________. This authorization is effective from _____________ until revoked by me in writing.	
3rd Authorized Party Last Name:	First Name:	Relation to Patient:
Phone Number:	This authorization is effective from _____________ through_____________. This authorization is effective from _____________ until revoked by me in writing.	

SIBLINGS

Last Name:	First Name:	Date of Birth:	Gender:
Last Name:	First Name:	Date of Birth:	Gender:
Last Name:	First Name:	Date of Birth:	Gender:
Last Name:	First Name:	Date of Birth:	Gender:

Margiotti & Kroll PEDIATRICS, P.C.

Patient Registration Forms

In order to serve you, we need the following information. Please print.

PRIMARY INSURANCE INFORMATON			
Insurance Company Name:	ID Number:		Group Number:
Guarantor's Name:	Gender:	Date of Birth:	Patient Relation to Guarantor:
Employer:		Employer Address:	
SECONDARY INSURANCE INFORMATON			
Insurance Company Name:	ID Number:		Group Number:
Guarantor's Name:	Gender:	Date of Birth:	Patient Relation to Guarantor:
Employer:		Employer Address:	

AUTHORIZATION FOR TREATMENT

- I hereby authorize all parents, guardians, family members, and caretakers listed above to accompany the above named patient to office visits at Margiotti & Kroll Pediatrics, P.C., and consent to the examination and/or treatment of the above named patient during the office visits. Parents and/or guardians must be listed above in order to obtain access to this patient's records via the Online Patient Portal.
- I certify that myself/my dependent(s) have health insurance coverage as indicated above. I hereby authorize Margiotti & Kroll Pediatrics, P.C. and/or its subsidiaries to submit for reimbursement on my/our behalf for all services rendered and assign directly to Margiotti & Kroll Pediatrics, P.C. all insurance benefits otherwise payable to me. I understand that all co-pays, co-insurances, and deductibles are due at the time of service and that a billing fee will be added to any co-pays not paid at the time of service. I further understand that if Margiotti & Kroll Pediatrics, P.C. is unable to verify active insurance coverage for this patient and/or the claim for reimbursement is not paid by my insurance that the patient (or patient's guardian, if a minor) is ultimately responsible for payment for services rendered. I agree that any balance due for services rendered will be paid immediately upon receipt of a bill. In the event that I do not pay my bill, I understand that I will be held responsible for all reasonable collection and legal fees.

Patient/Parent/Guardian Name:	Relationship to Patient:
Patient/Parent/Guardian Signature:	Date: