**4031 Pediatrics of Greater Houston, PLLC**
**Patient Registration Form (eCW)**

**PATIENT INFORMATION** (Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other_______________

Patient's Name (Last)______________________________ (First)________________________ (Middle)__________________

Also Known As Name (Last)__________________________________________(First)____________________________________

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Social Security Number _______-_____-_______ ☐ Female ☐ Male Date of Birth______/______/_______

E-Mail Address______________________________________________________________________________________

Phone Numbers Work_____________________ ☐ Day ☐ Evening Home____________________ ☐ Day ☐ Evening

Cellular___________________ Pager____________________

Address_____________________________________________________________________________________________

City, State, ZIP (+4)__________________________________________________________________________________

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer__________________________________________________ Occupation_____________________________________

Emergency Contact Name___________________________________________ Phone Number___________________________

Emergency Contact Relationship to Patient_______________________________________________________________

Referring Provider Name_____________________________________________________________________________

**RESPONSIBLE PARTY INFORMATION**

Responsible Party Name (Last)_____________________ (First)________________________ (Middle)__________________

Also Known As Name (Last)__________________________________________(First)____________________________________

Social Security Number _______-_____-_______ ☐ Female ☐ Male Date of Birth______/______/_______

E-Mail Address______________________________________________________________________________________

Phone Numbers Work_____________________ ☐ Day ☐ Evening Home____________________ ☐ Day ☐ Evening

Address_____________________________________________________________________________________________

City, State, ZIP (+4)__________________________________________________________________________________

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer__________________________________________________ Employer Phone Number__________________________

Patient Relationship to Responsible Party_______________________________________________________________

**PRIMARY INSURANCE INFORMATION** (provide your insurance card to the front desk at check-in)

Name of Insured____________________________________________ Patient Relationship to Insured______________________

Insured Employer Name_______________________________________________________________________________

Insurance Company/Phone Number__________________________________________________ (______)________________

Subscriber ID (Policy Number)___________________ Group ID__________________ Copay Amount____________________

Effective Date______________________ Termination Date______________________ ☐ Female ☐ Male

Insured Date of Birth_______/_______/_______ Insured's Social Security Number _______-_____-_______

Insurance Company Address___________________________________________________________________________

**SECONDARY INSURANCE INFORMATION** (provide your insurance card to the front desk at check-in)

Name of Insured____________________________________________ Patient Relationship to Insured______________________

Insured Employer Name_______________________________________________________________________________

Insurance Company/Phone Number__________________________________________________ (______)________________

Subscriber ID (Policy Number)___________________ Group ID__________________ Copay Amount____________________

Effective Date______________________ Termination Date______________________ ☐ Female ☐ Male

Insured Date of Birth_______/_______/_______ Insured's Social Security Number _______-_____-_______

Insurance Company Address___________________________________________________________________________

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

***Patient (or Responsible Party) Signature***_______________________________________________ ***Date***_________________