# Delaware Pediatric Patient Registration Form

2550 Delaware Avenue
Buffalo, New York 14216
(716) 884-0230

**Section 1** - ***If you have more than one child, please fill out one form for each child.***

**Page 1**

| Patient (Legal) Last Name | First Name (Legal) | Full Middle Initial |
|---|---|---|
| | | |

| Date of Birth | Sex | Gender |
|---|---|---|
| / / | Male ____ or Female ____ | Male ____ Female ____ Other ____ |

| Preferred Language | Do you need an interpreter? |
|---|---|
| English ____ Spanish ____ Other: | Yes ____ or No ____ |

| Ethnicity (circle one) | Race (circle one) |
|---|---|
| Hispanic or Latino/ Non-Hispanic or Latino or Unknown | Asian- Asian Indian- Asian Other / Black- African American / Caucasian Hawaiian- Pacific Islander / Native American- Alaskan Native /Multi-Racial Other: / Decline to State - Unknown |

**Section 2 – Mailing Address/Billing Address Information**

| Patient Address (Number, Street, Apt #) | City | State | Zip Code |
|---|---|---|---|
| | | | |
| ***Bill To Address (if same as above, leave blank)*** | City | State | Zip Code |
| | | | |

**Section 3 – Parent or Legal Guardian Information**

| Parent/Legal Guardian Of Minor | | Date Of Birth | Relationship to Minor |
|---|---|---|---|
| | | / / | |
| Phone 1 (Home, Cell, Work/Other) | ( ) - | Phone 2 (Home, Cell, Work/Other) | ( ) - |
| Maiden Name (***of birth mother)*** | | | |
| Email Address | **@** | **.com** or **.net** or ._____ (*circle one)* | |

| Parent/Legal Guardian Of Minor | | Date Of Birth | Relationship to Minor |
|---|---|---|---|
| | | / / | |
| Address if different (Number, Street, Apt #) | City | State | Zip Code |
| | | | |
| Phone 1 (Home, Cell, Work/Other) | ( ) - | Phone 2 (Home, Cell, Work/Other) | ( ) - |

**Section 4 – Primary Insurance Information**

| Insurance Holder Name (Subscriber) | Date of Birth | Relationship to Patient | Phone Number |
|---|---|---|---|
| | / / | | ( ) - |
| Employer & Health Plan Name | | | |
| Insurance ID number | | | |

**Section 5 - SECONDARY INSURANCE**

**(*if you do not have secondary insurance please leave blank.)***

| Insurance Holder Name (Subscriber) | Date of Birth | Relationship to Patient | Phone Number |
|---|---|---|---|
| | / / | | ( ) - |
| Health Plan Name | | | |
| Insurance ID number | | | |

| **PATIENT'S PAST MEDICAL HISTORY:** | |
|---|---|
| PLACE OF BIRTH: | |
| TYPE OF DELIVERY: | |
| WEIGHT AT BIRTH: LENGTH AT BIRTH: | |
| HOSPITALIZATIONS: | |
| OPERATIONS: | |
| SERIOUS ILLNESS: | |
| ALLERGIES: | |

| **FAMILY HISTORY:** | |
|---|---|
| (Please Indicate Relationship: Mother, Father, etc.) | |
| HEART DISEASE: | HAY FEVER: |
| DIABETES: | EPILEPSY: |
| HYPERTENSION: | ASTHMA: |
| ALLERGIES: | DRUG ALLERGIES: |
| ARTHRITIS: | ANEMIAS: |
| HIGH CHOLESTEROL: | SEIZURES: |
| OTHER: | |

| **Sibling's Names** | **Ages** | **Sibling's Names** | **Ages** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Referred By:** _____

**Employee Initials:** _____