

# 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 Male ___ or Female ___	Gender Male ___ Female ___ Other ___
Preferred Language English ___ Spanish ___ Other: _____	Do you need an interpreter? Yes ___ or No ___	
Ethnicity (circle one) Hispanic or Latino/ Non-Hispanic or Latino or Unknown	Race (circle all that apply) 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
<i>Bill To Address (if same as above, leave blank)</i>	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 ( <i>of birth mother</i> )		
Email Address @ .com or .net or ._____ ( <i>circle one</i> )		

Parent/Legal Guardian Of Minor	Date Of Birth / /	Relationship to Minor
Address if different (Number, Street, Apt #)	City	State
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			

<b>PATIENT'S PAST MEDICAL HISTORY:</b>			
PLACE OF BIRTH:			
OBSTETRICIAN (OB/GYN)			
TYPE OF DELIVERY:			
WEIGHT AT BIRTH:		LENGTH AT BIRTH:	
HOSPITALIZATIONS:			
OPERATIONS:			
SERIOUS ILLNESS:			
ALLERGIES:			

<b>FAMILY HISTORY:</b>	
(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: \_\_\_\_\_