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.***

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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 all that apply)
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			

Sibling's Names	Ages	Sibling's Names	Ages

Referred By: ____

Employee Initials: ________