dell children's
medical center of central texas
A member of the Seton Family of Hospitals

REGISTRATION FORM (PLEASE PRINT)

Pediatrician / Primary Care Doctor:	Today's Date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Age:	❑ Male ❑ Female	Date of Birth: / /
Street address:		Social Security no.:			Primary Phone Number: ( )
City	State	ZIP Code			Secondary Phone Number: ( )
Parent/Guardian Name:	Employer:				
	Employer phone no.: ( )				Email:
Social Security no.:					
Second Parent / Guardian Name:	Marital Status of Parents: ❑ Married ❑ Divorced ❑ Single				

INSURANCE INFORMATION

Name of Primary insurance:	**Subscriber's name:**	**Birth date:** / /	**Subscriber's S.S. no.:**	**Policy no.:**	**Group no.:**
Subscriber Address:			Patient's relationship to subscriber: ❑ Self ❑ Spouse❑ Child ❑ Other		
City	State		ZIP Code		
Name of Secondary insurance (if any):	Subscriber's name:		Subscriber DOB:		
			Subscriber's S.S. no. :		
Policy no.:	Group no.:	Relation	Employer:		

EMERGENCY CONTACT

Last name:	First:	Middle:	Email Cell: ( )
Street address:	Relationship to Patient:		Home phone no.: ( )
City	State	ZIP Code	

APPOINTMENT INFORMANTION

Referred by (Full name)	Reason for today's visit