Pediatric Associates of Lancaster * 1554 Wesley Way Lancaster Ohio 43130 * phone: 740-687-6386 * fax: 740-687-1388
Jennifer Miller MD * Michele Hensley MD * Michelle Golla MD * Rachael Hall CNP

Patient Registration Demographic Form

Patient Information:

Last Name _____ First Name _____ MI _____
D.O.B _____/_____/_____ Gender _____ Social Security # _____-_____-_____
Primary Language _____

(please circle)
Ethnicity: Hispanic / Non-Hispanic / Unknown / Declined to specify
Race: White / American Indian or Alaskan / Asian / Black or African American / Hawaiian or Pacific Islander / Declined to specify

Preferred Primary Doctor: Dr. Michele Hensley / Dr. Jennifer Miller / Dr. Michelle Golla

Patient Address:
Physical Address _____
Mailing Address/PO Box (if applicable) _____
City _____ County _____
State_____ Zip Code _____

Who lives in the household (please list by name and relation)?
_____

Patient Insurance:
Primary Policy: Policy Holder Name _____
Policy Holder Birth Date _____/_____/_____ Policy Holder Gender _____
Policy Holder SS# _____ Relation to patient _____
Insurance Carrier _____
ID#_____ Group # _____
Policy Effective Date _____

Secondary Policy: Policy Holder Name _____
Policy Holder Birth Date _____/_____/_____ Policy Holder Gender _____
Policy Holder SS# _____ Relation to patient _____
Insurance Carrier _____
ID#_____ Group # _____
Policy Effective Date _____

Contact 1 – Relationship to Patient**:** Mother / Father / Other _____
Last Name _____ First Name _____ MI _____
Lives with patient? Yes / No Maiden Name (if applicable) _____
SS # _____ Date of Birth _____/_____/_____
Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____
Work Phone (_____) _____-_____ Email _____
Employer_____ Occupation _____
Address (if different than Patient Address) _____

Contact 2* – Relationship to Patient**:** Mother / Father / Other _____
Last Name _____ First Name _____ MI _____
Lives with patient? Yes / No Maiden Name (if applicable) _____
SS # _____ Date of Birth _____/_____/_____
Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____
Work Phone (_____) _____-_____ Email _____
Employer_____ Occupation _____
Address (if different than Patient Address) _____

How would you ideally prefer to be contacted regarding (please circle):

Medical Issues*: Home phone / Work phone / Cell phone*
Appointment Reminders*: Home phone / Cell phone / email / text to cell phone*
Recall Notices*: Mailing address / Home phone / Work phone / Cell phone / e-mail / Text*
General Practice Notices*: Mailing address / Home phone / Cell phone / e-mail / Text*
Patient Portal Notifications*: Text to cell phone / e-mail*
*If Contact 2 will need to be notified *in addition to* Contact 1, please list contact preferences -
_____

Additional Contact Questions:

Who should receive billing statements _____
Marital Status of Parent(s) Married / Single / Divorced / Widowed / Separated
Patient/Child Cell Phone (_____) _____-_____ (if applicable, otherwise leave blank)

Emergency Contacts other than parents:

1. Name_____ Relationship _____
   Phone (_____) _____-_____
2. Name_____ Relationship _____
   Phone (_____) _____-_____

If parents are divorced, or separated, or if there are any custody issues, please fill out this section:
Who has custody? _____
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No
If yes, please explain and provide a copy of any legal paperwork that supports this restriction:

_____

****If you desire for any person to be assigned restricted access to medical information – please request a Restriction of Disclosure form at the front desk****

Form completed by:

Last Name _____ First Name _____

Relationship to Patient _____