Wee Care pediatrics Registration Form

Patient Information

Legal Last Name	Legal First Name	M.I.	Patient Date of Birth	Gender ☐M ☐F	Primary Care Physician

Street Address	City	State	Zip

Mobile Number	Home Number (if applicable)	Preferred Pharmacy	Pharmacy Location

Emergency Contact Name (Not living with you)	Relationship to patient	Emergency Contact Phone Number

Preferred Communication ☐ Text ☐ Mobile ☐ Email	Ethnicity	Race	Preferred Language

Parent / Responsible Party Information

Legal Last Name	Legal First Name	Date of Birth	Gender ☐ M ☐ F	SSN

Preferred Name	Relationship to Patient ☐ Parent ☐ Step-Parent ☐ Legal Guardian ☐ Other_____	Email

Street Address (If different than patient)	City	State	Zip

Mobile Number	Home Number (if applicable)	Preferred Communication (select one) ☐Text ☐ Mobile ☐ Email

Responsible Party Employer	Occupation	Responsible Party Work Phone/Ext.

Second Parent / Responsible Party Information

Legal Last Name	Legal First Name	Date of Birth	Gender ☐ M ☐ F	SSN

Preferred Name	Relationship to Patient ☐ Parent ☐ Step-Parent ☐ Legal Guardian ☐ Other_____	Email

Street Address (If different than patient)	City	State	Zip

Mobile Number	Home Number (if applicable)	Preferred Communication (select one) ☐ Text ☐ Mobile ☐ Email

Responsible Party Employer	Occupation	Responsible Party Work Phone/Ext.

Primary Insurance Information

Insurance Company	ID (Policy Number)	Group Number	Copay $	Effective Date

Policy Holder Name	Relationship to Patient ☐ Parent ☐ Step Parent ☐ Legal Guardian ☐ Other_____	Policy Holder Date of Birth

Policy Holder Employer	Policy Holder SSN

Secondary Insurance Information

Insurance Company	ID (Policy Number)	Group Number	Copay $	Effective Date

Policy Holder Name	Relationship to Patient ☐Parent ☐Step Parent ☐Legal Guardian ☐Other_____	Policy Holder Date of Birth

Policy Holder Employer	Policy Holder SSN

Authorized Signature_____ **Date**_____

Please bring this form along with your picture ID, insurance card(s) and applicable copay(s) to your appointment.

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