New Patient Registration Form

WELCOME TO MAZIQUE PEDIATRICS

We strive to ensure children are healthy by providing routine health assessments, childhood immunizations, same day sick appointments, telephone triage and most importantly 24-hour physician availability.

Patient Information

Name: _____

DOB: _____

Home Address: _____

_____

_____

(H) _____

Race: _____

Preferred Language: _____

Pharmacy Name & #: _____

Patient Prior Records Available Today? ☐ Y ☐ N

Primary Insurance Information

Policy Holder: _____

Relationship to Patient: _____

Social Security # : _____

Date of birth: _____

Name of Insurance: _____

Member ID#: _____

Group#: _____ Co-pay Amt: _____

Claims Address: _____

Telephone # for Providers: _____

PCP listed on card: _____

☐ Parent ☐ Guardian

Name: _____

Address: _____

Home#: _____ Cell: _____

Work: _____ Alt: _____

Email: _____

Employer: _____

Occupation: _____

☐ Parent ☐ Guardian

Name: _____

Address: _____

Home#: _____ Cell: _____

Work: _____ Alt: _____

Email: _____

Employer: _____

Occupation: _____

Parents Marital Status : ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Custody of Patient : ☐ Joint ☐ Sole to Mom ☐ Sole to Dad ☐ Other: _____

Secondary Insurance Information

Policy Holder:

Name:

SS#

DOB:

Relationship to Patient:

Name of insurance:

Member ID#:

Group#: Co-Pay:

Claims Address:

PCP listed on card:

Appointments& Information Release

Persons other than previously listed parents who are allowed to make appointments and discuss treatment:

Permission Given on:

Name

Relation to Patient:

Contact#

Contact#:

Email:

Emergency Contact Information

Name:

Contact#

Family/Medical History

Has the patient parents or anyone in the immediate family ever had any of the following diseases? If yes, please provide details in the additional space below. Patient has any Allergies?

Ear infections	☐	Asthma	☐	Wheezing	☐	Nose Bleeds	☐
Heart Murmurs	☐	Anemia	☐	Chicken Pox	☐	Polio	☐
Measles	☐	Mumps	☐	Scarlet Fever	☐	Headaches	☐
Diabetes	☐	Seizures	☐	Strokes	☐	Heart Disease	☐
Cancer	☐	HIV/AIDs	☐	High blood Pressure	☐	Depression	☐
Mental Illness	☐						

Are there any weapons in the house? If yes what?
Are there any smokers in the house? If yes who?
Is the patient on any medication? If yes give name
Is there any drug or alcohol use in the home? If yes who/how frequent
Family and other medical history

Authorization and release

I authorize Mazique Pediatrics P.C. to release any information including diagnosis and the medical records of any treatment or examination rendered to my child during the period of such care to third party payers and/or health practitioners. I also authorize and request my insurance to pay directly to Mazique Pediatrics P.C. insurance otherwise payable to me. I understand that my insurance may not pay for all billed services, therefore I take responsibility to pay all remaining balances for services rendered. It is my acknowledgement to pay any and all collections fees associated with care provided to my child.

Sign Name then Print Name of parent if patient is under 18 years old

Date