RAINBOW PEDIATRICS PATIENT REGISTRATION FORM

Select your preferred way to receive appointment reminders: ☐ Email ☐ Text Message ☐ Voicemail

CHILD'S FULL LEGAL NAME: (Print Please)	Date of Birth:	Social Security #:	Sex: ☐ Male ☐ Female
CHILD'S PREFERRED NAME:	Preferred Phone #:		
Mailing or Street Address (Where you receive your mail):	City, State, & Zip Code:		
Email Address: ☐ Mom ☐ Dad			
RACE: ☐ Asian ☐ Black or African American ☐ White or Caucasian ☐ Other: _____			
ETHNICITY: ☐ Hispanic/Latino ☐ Non-Hispanic	PRIMARY LANGUAGE: ☐ English ☐ Spanish ☐ Other: _____		

GUARANTOR(S)/LEGAL GUARDIAN(S) INFORMATION

(1) PARENT NAME: (Print Please)	Date of Birth:	Social Security #:	
Mailing or Street Address (If different from above):	Home #:	Work #:	Cell #:
PARENT'S EMPLOYER:			
(2) PARENT'S NAME: (Print Please)	Date of Birth:	Social Security #:	
Mailing or Street Address (If different from above):	Home #:	Work #:	Cell #:
PARENT'S EMPLOYER:			

EMERGENCY CONTACT: *(OTHER THAN PARENT(S)*

NAME:	Relationship to Patient:	Home #:	Cell #:

INSURANCE ONLY! PRIMARY Cardholder's Information

NAME:	Relationship to Patent:	Date of Birth:	Social Security #:
Mailing or Street Address (If different from above)	Home #:	Work #:	Cell #:

Primary Insurance:		Secondary Insurance (If available):	
Policy#:	Group#:	Policy#:	Group#:

Please select patient Primary Provider:

☐ TYLER ROGERS, MD ☐ ANNE BEVER, MD
☐ RYAN SCHOONOVER, CPNP ☐ MITCHELL ELLINGER, CPNP ☐ SARAH BALSTER, CPNP