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Jupiter Peds

TopLine MD Alliance

New Patient Registration

PATIENT'S INFORMATION – Please complete the following for your child.

Last Name:_____ First Name:_____ Middle Initial: _____

Male: ☐ Female: ☐ Patient Date of Birth: _____

Street Address: _____

City: _____ State:_____ Zip Code:_____ Phone:_____

Language Spoken at Home: _____ Name(s) of Sibling(s): _____

PATIENT'S INSURANCE – Please complete the following for your child.

Primary Insurance Co:_____ HMO ☐ PPO ☐ HEALTHYKIDS ☐ MEDICAID ☐

ID/Policy Number:_____ Group Number: _____

Policyholder's Name:_____ Policyholder's SS# ___-___-_____

Policyholder's Date of Birth: _____ Policyholder's Relationship to the Patient: _____

PARENT INFORMATION: *** MUST BE FILLED OUT COMPLETELY *****

Mother's Name: _____ Mother's Birth Date: _____ SS# ___-___-_____

Address: Same as Child ☐ or Different: _____

Mother's Email Address: _____

Cell Phone # : _____ Work Phone Number: _____ Extension #: _____

Employer Name:_____ Primary Insurance Holder: Yes ☐ No ☐

Father's Name:_____ Father's Birth Date:_____ SS# ___-___-_____

Address: Same as Child ☐ or Different: _____

Father's Email Address: _____

Cell Phone # : _____ Work Phone Number: _____ Extension #: _____

Employer Name:_____ Primary Insurance Holder: Yes ☐ No ☐

Please Check (if applicable): Custodial Parent(s) is/are: ☐ Mother ☐ Father ☐ Both

Emergency / Alternate Contact: : Authorized to bring the child to an appointment

Name:_____ Cell:_____ Work: _____

Name:_____ Cell:_____ Work: _____

I authorize that the above information is complete and correct. I authorize emergency/alternative contacts to bring my child to appointments and authorize medical care at the time of the visit.

Signature: _____ Relationship to Patient: _____ Date: _____