18 YEARS AND OLDER

Burlington Pediatrics

PATIENT REGISTRATION FORM

Patient's Name:_____**D.O.B**_____

Patient's Cell Number:_____**Home Number**:_____

Patient's Address:_____

E-Mail Address:_____

Emergency Contact Name/Number:_____

Legal Guardian (If none, please circle NONE):_____

Please circle **ONLY ONE** *preferred method of contact for each item listed below:*

Medical Issues: No Contact Home Phone Cell Phone Text to Cell Home E-mail

Reminders: No Contact Home Phone Cell Phone Text to Cell Home E-mail

Recalls: No Contact Home Phone Cell Phone Text to Cell Home E-mail

General Notices: No Contact Home Phone Cell Phone Text to Cell Home E-mail

Patient Portal: No Contact Text to Cell Home E-mail

Please circle:

Ethnicity: Hispanic Non-Hispanic Unknown Decline to Answer

Race: American Indian or Alaskan Native Asian Black or African American Hawaiian Native or Pacific Islander White Decline to Answer

Primary Language: English Spanish Other:_____

Secondary Language: English Spanish Other:_____

Who is the primary contact for patient? Mom Dad Other:_____

Who has legal custody of patient? Mom Dad Other:_____

With whom does the patient reside? Parent (joint) Mom only Dad only Other:_____

Patient/ Legal Guardian Signature:_____**Date:**_____