NEW PATIENT REGISTRATION	GLOBAL PEDIATRICS

Patient Information:		
Last Name:	First Name:	Middle:
Date of Birth:	Gender *(circle one)*: Male Female Other	
Address:		Apt. #
City:	State:	Zip:
Home Phone:	Work:	Cell:
Email address:		
Do you need an Interpreter: Y N	Preferred Language:	
*Race *(circle one)*: American Indian / Asian / Black or African American / Caucasian / Other / Declined *Ethnicity *(circle one)*: Hispanic / Non- Hispanic / Declined		
Marital Status:		
Emergency Contact Name:	Relationship:	
Emergency Contact Phone #:		

Physician Information:	
Primary Care MD Name:	Phone #:
Referring MD Name:	Phone #:
Pharmacy Name:	Phone #:

Guarantor Information: (*Person to be billed, if different from patient*)		
Last Name:	First Name:	Middle:
Date of Birth:		
Address:		Apt. #
City:	State:	Zip:
Home Phone:	Work Phone:	Cell:

Insurance/Coverage Information:		
Primary Insurance:	ID #:	Group #:
Insured's Last Name:	First:	DOB:
Secondary Insurance:	ID #:	Group #:
Insured's Last Name:	First:	DOB:

**The Centers for Medicare and Medicaid Services (CMS) require that we collect the following additional demographic information. Be assured that any information that WCPN collects related to race, ethnicity or language is used to provide care tailored to the needs of each patient*