



First Choice Pediatrics, Inc

www.fcpediatrics.com

407-249-1234

(F) 407-249-1755

New Patient Registration

Patient Name: \_\_\_\_\_ Birthday: \_\_\_\_\_

Age: \_\_\_\_\_ Social Security # \_\_\_\_\_  Female  Male

Home Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Home phone: \_\_\_\_\_

Mother: Name \_\_\_\_\_ Birthday \_\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_ Work phone \_\_\_\_\_ Cell# \_\_\_\_\_

Email address: \_\_\_\_\_  Use this email for appointment confirmations

Father: Name \_\_\_\_\_ Birthday \_\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_ Work phone \_\_\_\_\_ Cell# \_\_\_\_\_

Email address: \_\_\_\_\_  Use this email for appointment confirmations

Insurance company \_\_\_\_\_ ID# \_\_\_\_\_

Insurance phone # \_\_\_\_\_

You MUST provide a copy of the Insurance Card

Does anyone smoke in the house?  Yes  No

Any pet?  Inside  Outside

Pharmacy name: \_\_\_\_\_ Pharmacy phone # \_\_\_\_\_

In case of emergency, notify: (Other than parents)

Name \_\_\_\_\_ Home phone \_\_\_\_\_

Name \_\_\_\_\_ Home phone \_\_\_\_\_

Please List the person (s) that you authorize to accompany the child and give consent for treatment for at appointment time, other than parent:

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship to child \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship to child \_\_\_\_\_

Family and Child/Children past History Please list below

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of parent/Legal Guardian of Minor \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Parent/Minor \_\_\_\_\_ Witness by \_\_\_\_\_

\*\*\*Please complete and sign both front and back of patient registration\*\*\*

