New Patient Registration

Date: ______________________

Parent/Guardian's Name: _______________________________________ Phone #: ___________________________

Parent/Guardian's Name: _______________________________________ Phone #: ___________________________

Previous patient of Dr. Bell? Yes No If no, prior pediatrician: ___________________________

Reason for leaving: ____

Up to Date on Immunizations? Yes No

If not, are you willing to get caught up? Yes No

Insurance Carrier: ____

Insurance ID Number: ____________________ Group: _________________________

(Please note: KidMed cannot accept marketplace insurance plans)

Please list each child's information, use additional pages as necessary.

Child 1 Full Name: ____

DOB: ______________________ Age: ______________ Male Female

City and Hospital of Birth: _______________________________ Gestational Age at birth: __________ weeks

Child 2 Full Name: ____

DOB: ______________________ Age: ______________ Male Female

City and Hospital of Birth: _______________________________ Gestational Age at birth: __________ weeks

Child 3 Full Name: ____

DOB: ______________________ Age: ______________ Male Female

City and Hospital of Birth: _______________________________ Gestational Age at birth: __________ weeks

Major Medical Concerns: ____

____

____

Internal Use Only: Accepted - Denied - Pending Initials of Staff: __________