Date:_____

KidMed
Feel better.

New Patient Registration

Parent/Guardian's Name: _____ Phone #: _____

Parent/Guardian's Name: _____ Phone #: _____

Mailing Address: _____

_____

Email Address: _____

Previous patient of Dr. Bell? ___Yes ___No If no, prior pediatrician: _____

Reason for leaving: _____

Patients of KidMed are required to stay up to date on immunizations per the CDC schedule:

Are your children up to date on Immunizations? ___Yes ___No

If not, are you willing to get caught up, per the CDC schedule? ___Yes ___No

Insurance Carrier: _____

Insurance ID Number: _____ Group: _____

Subscriber/Insured Name: _____ Subscriber/Insured DOB: _____

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

Any Major Medical Conditions or Concerns: _____

_____

_____

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