314 E. Main Street • Suite 101 • Newark, DE 19711
Phone (302) 738-4800 • Fax (302) 738-8750 • www.newarkpediatrics.com

FAMILY REGISTRATION FORM

Please PRINT and provide all information requested

PARENT/GUARDIAN RESP FOR BILL:___________________________PRIMARY PHONE________________________

CELL PHONE____________________________EMAIL ____

STREET ADDRESS_____________________________________CITY___________________STATE_____ ZIP______

PARENT___________________________ EMPLOYER___________________________ PHONE___________________

PARENT___________________________ EMPLOYER___________________________ PHONE___________________

PHARMACY NAME, ADDRESS & PHONE #____

PRIMARY INSURANCE CO______________________ I.D.#____________________DOB _________ Father ☐ Mother ☐

(For Delaware Policy Holders – your children's primary coverage is under the policy of the parent whose birthday falls the earliest in the calendar year)

SECONDARY INSURANCE CO____________________I.D.#____________________DOB__________ Father ☐ Mother ☐

CHILDREN'S NAMES:

Name_______________________________ DOB __________________ SEX (circle one) M F
Primary Language: English ☐ Other _________________ ☐
Race_________________________ Ethnicity: Hispanic/Latino ☐ Non-Hispanic/Latino ☐

Name_______________________________ DOB ________________ SEX (circle one) M F
Primary Language: English ☐ Other _________________ ☐
Race_________________________ Ethnicity: Hispanic/Latino ☐ Non-Hispanic/Latino ☐

Name_______________________________ DOB ________________ SEX (circle one) M F
Primary Language: English ☐ Other _________________ ☐
Race_________________________ Ethnicity: Hispanic/Latino ☐ Non-Hispanic/Latino ☐

Name_______________________________ DOB_________________ SEX (circle one) M F
Primary Language: English ☐ Other _________________ ☐
Race_________________________ Ethnicity: Hispanic/Latino ☐ Non-Hispanic/Latino ☐

I hereby authorize Newark Pediatrics, PA to furnish information to insurance carriers concerning my dependent's illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered. I understand that I am responsible for any amount not covered by my insurance.

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Signature Parent/Guardian Date