Iberia Pediatrics

****UPDATED REGISTRATION FORM****

Please select patient(s) Primary Provider: ☐ BOUDREAUX ☐ FAUGOT ☐ RADER

Select your preferred way to receive appointment reminders: ☐ Email ☐ Text Message ☐ Voicemail

CHILD'S FULL LEGAL NAME: (Print Please)	Date of Birth:	Social Security #:	Sex: ☐ Male ☐ Female
Mailing or Street Address (Where you receive your mail):	Preferred Phone #:		
City, State, & Zip Code:	Secondary Phone #:		
PARENT EMAIL ADDRESS:			

:: PLEASE LIST ADDITIONAL CHILDREN THAT YOU ARE RESPONSIBLE FOR THAT ARE ALSO PATIENTS HERE ::

CHILD'S FULL LEGAL NAME: (Print Please)	Date of Birth:	Social Security #:	Sex: ☐ Male ☐ Female
CHILD'S FULL LEGAL NAME: (Print Please)	Date of Birth:	Social Security #:	Sex: ☐ Male ☐ Female
CHILD'S FULL LEGAL NAME: (Print Please)	Date of Birth:	Social Security #:	Sex: ☐ Male ☐ Female

::PARENT(S)/LEGAL GUARDIAN'S INFORMATION:

MOTHER'S NAME: (Print Please)	Date of Birth:	Social Security #:	
Mailing or Street Address (If different from above):	Home#:	Work#:	Cell#:
MOTHER'S EMPLOYER:			
FATHER'S NAME: (Print Please)	Date of Birth:	Social Security #:	
Mailing or Street Address (If different from above):	Home#:	Work#:	Cell#:
FATHER'S EMPLOYER:			

:: EMERGENCY CONTACT *(OTHER THAN PARENT(S))* ::

NAME:	Relationship to Patient:	Home#:	Cell#:

:: INSURANCE ONLY! **PRIMARY Cardholder's Information (Person financially responsible) ::

NAME:	Relationship to Patient:	Date of Birth:	Social Security #:
Mailing or Street Address (If different from above)	Home #:	Work #:	Cell #:

Primary Insurance:		Secondary Insurance (If applicable):	
Policy#:	Group#:	Policy#:	Group#:

*** * ALL PATIENTS ARE ASKED TO PRESENT A COPY OF THE INSURANCE CARD(S) AND ID AT EVERY VISIT ****

DATE: _____ SIGNATURE OF GUARANTOR/LEGAL GUARDIAN: _____