Lancaster Pediatrics, PA
2850 North Ridge Road, Suite 203
Ellicott City, MD 21043
(o) (410) 480-2803 (fax) (410) 480-2806

NEW PATIENT REGISTRATION

Date: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I.: _____ Sex: M / F

Birth Date: _____/_____/_____ Age: _____

Address: _____
Street *City* *State* *Zip*

Phone: Home: ( ) Cell: ( ) Work: ( )

Languages Spoken at Home:_____

Birth History: ____ C-Section _____ Vag ; _____Full Term or born around expected due date

Or ____Premature, if premature born at _____weeks.

Born at _____Hospital or Birthing Center.

Complications at or directly after birth (including stay in NICU) : _____

_____

Allergies to medications or foods:_____

_____

Current medications:_____

_____

Current Health Issues (such as asthma, diabetes, heart problems, cystic fibrosis, sickle cell disease, leukemia, kidney problems, frequent urinary tract infections, ADHD, learning disabilities, autism, developmental delay, cerebral palsy, eye problems including glasses, hearing issues, or other health concerns):

_____

Past Health Issues including hospitalizations and emergency room visits:

_____

_____

SIBLING INFORMATION

Last Name: _____ First Name: _____ M.I.: _____ Sex: M / F

Birth Date: _____/_____/_____ Age: _____

Last Name: _____ First Name: _____ M.I.: _____ Sex: M / F

Birth Date: _____/_____/_____ Age: _____

Last Name: _____ First Name: _____ M.I.: _____ Sex: M / F

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Last Name: _____ First Name: _____ M.I.: _____ Sex: M / F

Birth Date: _____/_____/_____ Age: _____

Last Name: _____ First Name: _____ M.I.: _____ Sex: M / F

Birth Date: _____/_____/_____ Age: _____

PARENT INFORMATION

Last Name: _____ First Name: _____ M.I.: _____ Sex: M / F

Birth Date: _____/_____/_____ Age: _____ Social Security #: _____-_____-_____

Email address_____ ____Check if address is same as patient's address OR

Address: _____
Street *City* *State* *Zip*

Phone: Home: ( ) Cell: ( ) Work: ( )

*Which is the best number to contact you during business hours?*_____

Occupation: _____ Employer: _____

PARENT INFORMATION

Last Name: _____ First Name: _____ M.I.: _____ Sex: M / F

Birth Date: _____/_____/_____ Age: _____ Social Security #: _____-_____-_____

Email address_____ ____Check if address is same as patient's address OR

Address: _____
Street *City* *State* *Zip*

Phone: Home: ( ) Cell: ( ) Work: ( )

*Which is the best number to contact you during business hours?*_____

Occupation: _____ Employer: _____

EMERGENCY CONTACT INFORMATION

Name of friend or relative (not living at the same address) _____

Home phone: _____ Cell or Work Phone: _____

HOW YOU LEARNED ABOUT LANCASTER PEDIATRICS, PA

Referred to Dr. Lancaster by: _____

(Please check one):

__ Doctor __ Insurance Plan __ Family Member __ Friend
__ Yellow Pages __ Internet __ Previous Patient
__ Other: _____

INSURANCE INFORMATION

Primary Insurance Policy Name: _____

Group Number:_____ Policy Number:_____

Subscriber's Name: _____ Subscriber's Birthdate: _____/_____/_____

Relationship to Subscriber (Circle): Self / Child / Grandchild / Other

Secondary Insurance Policy Name: _____

Group Number: _____ Policy Number:_____

Subscriber's Name: _____ Subscriber's Birthdate: _____/_____/_____

Relationship to Subscriber (Circle): Self / Child/ Grandchild/ Other

I authorize my insurance benefits to be paid directly to the physician.
I understand that I am financially responsible for the services provided. I also authorize Duniya R. Lancaster, MD and Lancaster Pediatrics, PA, or my insurance company to release any information required to process my claim.

Patient / Guardian Signature: _____ Date: _____/_____/_____