LOCKPORT PEDIATRICS
175 Walnut St., Suite 5
Lockport, NY 14094
Phone: (716) 433-6711 | Fax: (716) 433-6712
Website: www.lockportpediatrics.com

NEW PATIENT REGISTRATION FORM

(Please print clearly and complete all sections)

1. PATIENT INFORMATION (CHILD)

- **Last Name:** _____ **First Name:** _____ **MI:** ____
- **Date of Birth (MM/DD/YYYY):** _____ / _____ / _____
- **Gender:** [ ] Male [ ] Female
- **Home Address:** _____
- **City:** _____ **State:** NY **Zip Code:** _____
- **Preferred Pharmacy Name & Location:** _____

2. PARENT / GUARDIAN INFORMATION

Parent/Guardian #1 (Primary Contact)

- **Name:** _____
- **Relationship to Patient:** [ ] Mother [ ] Father [ ] Legal Guardian [ ] Other: _____
- **Date of Birth:** _____ / _____ / _____
- **Cell Phone: () _____ - _____ Work Phone: ()** _____ - _____
- **Email Address:** _____
- **Address (if different from patient):**

  _____

Parent/Guardian #2

- **Name:** _____
- **Relationship to Patient:** [ ] Mother [ ] Father [ ] Legal Guardian [ ] Other: _____
- **Date of Birth:** _____ / _____ / _____
- **Cell Phone: () _____ - _____ Work Phone: ()** _____ - _____

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3. INSURANCE INFORMATION

(Please present your insurance card to the receptionist upon arrival)

Primary Insurance

- **Insurance Company Name:**

  _____

- **Policy / ID Number:** _____ **Group Number:**

  _____

- **Policy Holder's Name:**

  _____

- **Policy Holder's Date of Birth:** _____ / _____ / _____

- **Relationship to Patient:** [ ] Self [ ] Parent [ ] Spouse [ ] Other

Secondary Insurance (if applicable)

- **Insurance Company Name:**

  _____

- **Policy / ID Number:** _____
- **Policy Holder's Name:**

  _____

4. EMERGENCY CONTACT

(Contact person other than parents/guardians listed above)

- **Name:** _____
- **Relationship to Child:** _____
- **Phone Number:** (_____) _____ - _____

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5. AUTHORIZATION & CONSENT

Consent to Treat:
I voluntarily consent to such medical care and treatment as may be prescribed by the physician(s) or nurse practitioner(s) of Lockport Pediatrics for the patient listed above.
Financial Responsibility:
I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the release of any medical information necessary to process insurance claims. I authorize payment of medical benefits directly to Lockport Pediatrics.
Acknowledgment of Privacy Practices:
I acknowledge that I have received or been offered a copy of Lockport Pediatrics' Notice of Privacy Practices (HIPAA).

Signature of Parent/Legal Guardian:
_____

Printed Name: _____

Date: _____ / _____ / _____