

Practice EHR – TRICIDES PEDIATRICS

PATIENT REGISTRATION FORM

Patient Enrollment

Account #:	<u>105248</u>	First Name:	<u>Sophie</u>
MJ:	<u>J</u>	Last Name:	<u>Anderson</u>
DOB:	<u>04/10/2009</u>	Sex:	<u>Female</u>
Marital Status:	<u>Single</u>		
Address1:	<u>5678 Willow Drive</u>	<u>Apt 303</u>	
City:	<u>Cedar Rapids</u>	State, Zip:	<u>52403</u>
Home Phone:	<u>(319) 555-0158</u>	Ext:	<u>102</u> <u>Cell Phone</u>

Primary Care Physician

Name:	<u>Dr. Jennifer Harris</u>	Phone:	<u>(319) 555-8463</u>
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Emergency Contact Info

Last Name:	<u>James</u>	Home Phone:	<u>Eleanor</u>
Work Phone:	<u></u>		<u></u>

Primary Insurance Info

Insurance:	<u>Blue Cross</u>	State, Zip:	<u>IA. 22403</u>
DO #:	<u>Female</u>	Sex:	<u>Female</u>

Primary Insured *Completed only if different than patient*

First Name:	<u>Sophie</u>	Last Name:	<u>Anderson</u>
DOB:	<u>5678 Willow Drive</u>	Home Phone:	<u>5678 Willow Drive</u>
Address:	<u>Cedar Rapids</u>	State, Zip:	<u>Cedar Rapids</u>
City:	<u>52403</u>	State, Zip:	<u>52403</u>