WNY Pediatric ENDOCRINOLOGY

# New Patient Registration Form

**PATIENT INFORMATION:**

**Patient Name:** ________________________________________ **Sex (at birth):** M F

Preferred Name: ________________________________________ Gender Identity: M F Other

Birth date: ____________________________

Address: ______________________________________________________________________

City: ______________________________ State: _____________ Zip: ____________________

Home Phone: ____________________ Mobile Phone :__________________

E-mail address: ________________________________________________________________

Race: White Black/African American Asian Other: _________________

Ethnicity: Spanish/Hispanic Non Hispanic

Primary Language: ______________________________

---

**Parent 1 Name:** ________________________________________

Address (if different from patient): ______________________________________________________

City: _____________________________ State: _____________ Zip: _____________________

Birth date: ____________________________

Home Phone: _____________________ Mobile Phone: ___________________

---

**Parent 2 Name:** _______________________________________

Address (if different from patient): _____________________________________________________

City: ___________________________ State: ______________ Zip: _____________________

Birth date: ____________________________

Home Phone: _____________________ Mobile Phone: ____________________

---

Health Insurance: _________________________________ Subscriber ID#: ____________________

Policy Holder Name: _____________________________ DOB: __________________________

Secondary Health Insurance: _________________________ Subscriber ID#: ____________________

---

Primary Pharmacy: _____________________________ Phone #: ___________________________