Louisville **Pediatric** Specialists
6081 Dixie Hwy Suite 127
Louisville, KY 40258
Phone: (502) 935-5633 Fax: (502) 935-5706

Thomas C. Hubbs, MD, FAAP
John W. Kim, MD. FAAP
Tracee L. Wojtkowski, MD, FAAP
Christina S. Brown, MD

Family Registration

Patient Information			
Please list all children in the family for which the following information applies. Call our office any time demographic information changes.			
Name:	SSN:	DOB:	Gender:
Name:	SSN:	DOB:	Gender:
Name:	SSN	DOB:	Gender:
Name:	SSN:	DOB:	Gender
Address:			
City, State, Zip Code:			
Primary Language Spoken in The Home:			
Race:		Ethnicity: NON-HISPANIC HISPANIC DECLINE	
Emergency Contact (Outside of the Home):		Emergency Contact Phone:	
Pharmacy:		Pharmacy Phone:	
How did you hear about our practice?			

Parent/Guardian Information			
Name:		Name:	
Relation to Child:		Relation to Child:	
DOB:	SSN:	DOB:	SSN:
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Phone:		Phone:	
Cell Phone:		Cell Phone:	
Employer:		Employer:	
Email:		Email:	
If parents are divorced or separated or there a custody agreement in place, please complete the following section.			
Who has primary custody?			
Are there any legal restrictions that would keep the non-custodial parent from consenting to medical treatment for the child, or from obtaining information about the child's medical treatment? YES / NO			

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Insurance Information	
Primary Insurance:	Employer:
Member/Subscriber ID:	Group #:
Subscriber's Name:	DOB:
Subscriber's SSN:	Relationship to Patient:
Secondary Insurance:	Employer:
Member/Subscriber ID:	Group #:
Subscriber's Name:	DOB:
Subscriber's SSN:	Relationship to Patient:

Contact Preferences Circle any method at which we may contact you.	
Cell/Text	E-Mail
Postal Mail	Telephone
Is it ok to leave a message on any of the numbers you have provided? YES / NO	

Health Information Privacy	
I give the below individual(s) permission to make medical decisions regarding my child(ren) and have my child(ren) receive treatment under their supervision. I understand that it is the office policy NOT to have my child receive vaccinations or have well visits, however, without a parent or legal guardian present.	
Name:	Relation to Patient:
Name:	Relation to Patient:
Name:	Relation to Patient:
Name:	Relation to Patient:
May we discuss your child(ren)'s medical care with anyone other than the parent/guardians listed on this form? YES / NO	
If yes, whom?	Phone #:

By signing below, you are confirming that you have completed this information completely and accurately. If you would like to see a copy of our Notice of Privacy Practices please see someone at the front desk.

Signature: ______________________________ **Date:** ____________________