

Patient Registration

Albemarle Pediatrics

1420 US Hwy 52N, Suite A  
(704) 982-KIDS(5437)

Albemarle, NC 28001

Guarantor Information

Patient Last Name \_\_\_\_\_

Patient First Name \_\_\_\_\_

Patient Middle Name \_\_\_\_\_

Patient Sex \_\_\_\_\_ Patient DOB \_\_\_\_\_

Patient Language \_\_\_\_\_

Patient Race \_\_\_\_\_ Patient Ethnicity \_\_\_\_\_

Address \_\_\_\_\_

Zip \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Phone # \_\_\_\_\_

Biological Father Last Name \_\_\_\_\_

Biological Father First Name \_\_\_\_\_

Father's Employer \_\_\_\_\_

Employer Phone \_\_\_\_\_ DOB \_\_\_\_\_

Biological Mother Last Name \_\_\_\_\_

Biological Mother First Name \_\_\_\_\_

Mother's Maiden Name \_\_\_\_\_

Mother's Employer \_\_\_\_\_

Mother's Employer Phone \_\_\_\_\_ DOB \_\_\_\_\_

Emergency Contact Name & Number \_\_\_\_\_

**guarantor (name to whom statements are sent)**

Guarantor Last Name \_\_\_\_\_

Guarantor First Name \_\_\_\_\_

Guarantor Middle Name \_\_\_\_\_

*guarantor address (if different from patient's)*

Guarantor Address \_\_\_\_\_

Guarantor Zip \_\_\_\_\_

Guarantor City \_\_\_\_\_

Guarantor State \_\_\_\_\_

Guarantor Phone \_\_\_\_\_

Guarantor Employer \_\_\_\_\_

Father's Mobile Phone# \_\_\_\_\_

Mother's Mobile Phone# \_\_\_\_\_

EMAIL \_\_\_\_\_

Are there any other family members who are patients here: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any Step-Parent information if applicable:

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Legal Guardian: Yes  No

(Most provide legal documents)