Welcome to Reading Pediatric Associates PC

Please take a moment to fill out this form for each patient so that we can better assist you.

Patient and Family Information:

Patients Name: _____

Date of Birth: _____ Male: _____ Female: _____

Race: _____ Ethnicity: _____ Language Preference: _____

Patients Address: _____

City: _____ State: _____ Zip Code:_____

Home Phone:_____ Preferred Phone (Please Circle One): Home Cell

Parents Name: (Mother)_____ (Father)_____

Cellular Phone: (Mother)_____ (Father) _____

Work Phone: (Mother)_____ (Father) _____

E-Mail address: _____

Please list any other Siblings already with our practice:_____

Would you like to receive text reminders for upcoming appointments, and flu clinics? Yes No

How did you hear about us: Internet Search Yelp Referred by Family or Friend Other (Specify): _____

If referred by family or friend, who can we thank for referring you? _____

Insurance Information: (please be prepared to show us your insurance card)

Name of Insurance: _____

Policy Number: _____

Subscriber Name: _____ DOB: _____

Primary Care Information:

Who will be your child's Primary Care Provider in the practice? _____

What hospital was your child born in? (Only Applicable for Newborns) _____