STEPS FOR KIDS

REGISTRATION FORM

(Please Print)	
Today's date: / /	Primary Care Provider:

CAREGIVER INFORMATION

Caregiver's last name:	First:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Age:	Sex: ❑ M ❑ F ❑ O	Latino or Hispanic?	❑ Yes ❑ No	
Home phone no.:	Cell:			Email:
Street address:				
City:	State:	ZIP Code:		
Occupation:				

Referred by (please check one box):	❑ Doctor	❑ Community Organization	❑ Family member	❑ Web Search	❑ Insurance Plan
❑ Hospital	❑ Friend	❑ Other			
Other family members who have participated in STEPS?	*(Please list)*				

INSURANCE INFORMATION

Is this patient covered by insurance? ❑ Yes ❑ No

CHILD INFORMATION

Child's last name:	First:	Preferred:
Birth date: / /	Age:	Sex: ❑ M ❑ F ❑ O
Latino or Hispanic? ❑ Yes ❑ No	Race: ❑ Black ❑ White ❑ Asian ❑ Native American/ Indigenous ❑ Multiracial ❑ Other	

CHILD INFORMATION

Child's last name:	First:	Preferred:
Birth date: / /	Age:	Sex: ❑ M ❑ F ❑ O
Latino or Hispanic? ❑ Yes ❑ No	Race: ❑ Black ❑ White ❑ Asian ❑ Native American/ Indigenous ❑ Multiracial ❑ Other	

CHILD INFORMATION

Child's last name:	First:	Preferred:
Birth date: / /	Age:	Sex: ❑ M ❑ F ❑ O
Latino or Hispanic? ❑ Yes ❑ No	Race: ❑ Black ❑ White ❑ Asian ❑ Native American/ Indigenous ❑ Multiracial ❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):		Relationship to patient:	
Home phone no.:		Work phone no.:	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize STEPS for kids or insurance company to release any information required to process my claims.

Patient/Guardian signature	Date