J.J. Saenz, M.D. ● Daniella Rodriguez-Rico, M.D. ● Jennifer E. Saenz, M.D.
Marla Garza PA-C ● Melissa Ledesma PA-C ●Erica Tijerina, PA-C

2821 Michael Angelo Dr. Suite 102 ● Edinburg, Texas 78539
956-686-6100 (Office) ● 956-686-6115 (Fax)
Monday – Friday 8AM – 5PM, Saturdays 8AM – 1PM

FAMILY REGISTRATION FORM

Today's Date___/___/___

CHILD'S NAME (First, Middle, Last)	SEX (circle)	DATE OF BIRTH	ETHNICITY	RACE	PCP
	M F		☐Hispanic or Latino ☐Not Hispanic or Latino ☐Prefer not to answer		☐ JJ Saenz ☐ Rodriguez-Rico ☐ JE Saenz
	M F		☐Hispanic or Latino ☐Not Hispanic or Latino ☐Prefer not to answer		☐ JJ Saenz ☐ Rodriguez-Rico ☐ JE Saenz
	M F		☐Hispanic or Latino ☐Not Hispanic or Latino ☐Prefer not to answer		☐ JJ Saenz ☐ Rodriguez-Rico ☐ JE Saenz
	M F		☐Hispanic or Latino ☐Not Hispanic or Latino ☐Prefer not to answer		☐ JJ Saenz ☐ Rodriguez-Rico ☐ JE Saenz

	PARENT/GUARDIAN #1	PARENT/GUARDIAN #2
Name:		
Relationship to Patient(s):		
Date of Birth:		
Home Address:		
Home Phone #:		
Cell Phone #:		
Work Phone #:		
Email Address:		
Employer:		
Occupation:		
Preferred Language:		

Parents are: ☐Married ☐ Living Together ☐Separated ☐ Divorced (if divorced, who is the Custodial Parent? ☐#1 or ☐#2

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PATIENT CONFIDENTIAL COMMUNICATION PREFERENCE

Is it okay to leave a voicemail regarding labs/medical information: ☐ Yes ☐ No

If yes, who is the preferred contact? _____ Preferred Phone #: _____

Pediatric Center at Renaissance will provide appointment reminders and contact you to keep you informed of any new services or upcoming events. Who is the preferred contact person? ☐ Parent #1 ☐Parent #2

How would you like to be contacted? (select one)

☐ Mailing Address ☐ Cell Phone ☐ Work Phone ☐ Home Phone☐ Email ☐ Text Message

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At times you may not be able to bring your child in for treatment. Please specify any other adult 18 years or older that is able to act on your behalf in authorizing medical treatment: (i.e., grandparent, aunt, uncle, etc.). Please check next to the person that you want as the emergency contact in case we are not able to get a hold of either parent/guardian.

NAME	ADDRESS	PHONE #	RELATIONSIP	EMERGENCY CONTACT?
				☐ YES ☐ NO
				☐ YES ☐ NO

MEDICAL INSURANCE INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company:		
Carrier Phone #:		
Policy #:		
Group #:		
Policy Holder:		
Date of Birth:		
Relation to Patient:		

Do you have Medicaid insurance? ☐ No ☐ Yes If yes, please complete the table below for any child on a Medicaid plan.

CHILD'S NAME	MEDICAID PLAN	CERTIFICATE NUMBER