Washington International
Pediatrics

WELCOME!

New Patient Registration Form

Patient(s) Information

Child #1: _____ ☐Male ☐ Female ☐Other/Non-Binary DOB: _____

Child #2: _____ ☐Male ☐ Female ☐Other/Non-Binary DOB: _____

Child #3: _____ ☐Male ☐ Female ☐Other/Non-Binary DOB: _____

Child #4: _____ ☐Male ☐ Female ☐Other/Non-Binary DOB: _____

Child #5: _____ ☐Male ☐ Female ☐Other/Non-Binary DOB: _____

Home Address: _____Apt._____

City: _____State: _____Zip: _____

Parent #1

Name: _____ ☐Male ☐ Female ☐Other/Non-Binary DOB: _____

Address (if different from patient's):

Address: _____Apt._____

City: _____State: _____Zip: _____

Primary Phone Number: _____ E-mail: _____

Profession: _____

Parent #2

Name: _____ ☐Male ☐ Female ☐Other/Non-Binary DOB: _____

Address (if different from patient's):

Address: _____Apt._____

City: _____State: _____Zip: _____

Primary Phone Number: _____ E-mail: _____

Profession: _____