PATIENT REGISTRATION

Last Name: _____ First Name: _____ MI: _____

Preferred Name: _____ D.O.B.: _____ Sex: _____ ___

Street Address:_____ Apartment/Unit Number #: City:

State ZIP Code

Home Phone: _____Cell Phone: _____ Email Address:

Parent/Contact 1: Name: _____ Relation to Patient: _____

Date of Birth: _____ Lives with patient? ☐ Yes ☐ No, _____

Work Phone: _____ Cell Phone: _____

Home Email: _____ Work Email: _____

Parent/Contact 2: Name: _____ Relation to Patient: _____

Date of Birth: _____ Lives with patient? ☐ Yes ☐ No, _____

Work Phone: _____ Cell Phone: _____

Home Email: _____ Work Email: _____

Primary Policy: Policy Holder's Name: _____ Policy Holder's Birth Date: _____

Insurance Carrier: _____ Insurance Address: _____

Member ID # _____ Category/Group # _____

Co-Pay Amount $: _____ Policy Effective Date: _____

Emergency Contact:

Name & Relationship: _____/_____ Phone: _____

Pharmacy Information:

Name: _____ Address: _____ Phone: _____

This information that I have given is correct and true to the best of my knowledge. Understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

_____ _____

Signature of Patient or Parent/Legal Representative **Date**