Patient Registration Form

****YOUR APPOINTMENT MAY BE CANCELLED IF YOU DO NOT HAVE YOUR COPAY AND INSURANCE CARD****

PATIENT INFORMATION:

NAME: _____

DOB: _____ **AGE:** _____ **SEX:** _____

ADDRESS: _____ **APT#** _____

CITY: _____ **STATE** _____ **ZIP** _____

HOME PHONE: _____ **WORK PHONE:** _____

CELL PHONE: _____ **SSN:** _____

ETHNICITY: _____ **RACE:** _____

DOES PATIENT LIVE WITH BOTH PARENTS: _____ **IF NO, WHO DOES PATIENT LIVE WITH:** _____

DOES PATIENT HAVE INSURANCE FROM BOTH PARENTS: _____

IF YES, PLEASE LIST ALL INSURANCES PATIENT HAS UNDER BOTH PARENTS: _____

RESPONSIBLE PARTY INFORMATION (PARENT/GUARDIAN):

NAME: _____

ADDRESS: _____ **APT#** _____

CITY: _____ **STATE** _____ **ZIP:** _____

HOME PHONE: _____ **CELL PHONE:** _____

EMERGENCY CONTACT INFORMATION:

FIRST NAME: _____ **LAST NAME:** _____

HOME PHONE: _____ **CELL PHONE:** _____

RELATIONSHIP TO PATIENT: _____

PATIENT PRIMARY CARE PHYSICIAN:

FIRST NAME: _____ **LAST NAME:** _____

PRACTICE NAME: _____ **PHONE NUMBER:** _____

ADDRESS: _____ **SUITE#** _____

CITY: _____ **STATE** _____ **ZIP:** _____

****PLEASE PROVIDE OUR OFFICE WITH YOUR CHILD'S CURRENT INSURANCE CARD****

PRIMARY INSURANCE INFORMATION:

INSURANCE NAME _____ **COPAY AMOUNT:** _____

ID. NUMBER: _____ **PLAN/GROUP#:** _____

POLICYHOLDER NAME: _____ **DOB:** _____ **SSN:** _____

POLICYHOLDER ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PATIENT RELATIONSHIP TO THE POLICYHOLDER: _____

SECONDARY INSURANCE INFORMATION: **NONE** ☐

INSURANCE NAME _____ **COPAY AMOUNT:** _____

ID. NUMBER: _____ **PLAN/GROUP#:** _____

POLICYHOLDER NAME: _____ **DOB:** _____ **SSN:** _____

PATIENT RELATIONSHIP TO THE POLICYHOLDER: _____

TERTIARY INSURANCE INFORMATION: **NONE** ☐

PLEASE INFORM FRONT DESK OFFICE IF TERTIARY INSURANCE IS APPLICABLE.

PARENT SIGNATURE: _____ **DATE:** _____

PARENT PRINTED NAME: _____ **STAFF INITIALS:** _____ **DATE:** _____