Insurance cards copied ❑
Date: ______________

Child Registration Information

Account #: ______________
Insurance #: ______________
Co-Payment: $ ______________

Please PRINT AND complete ALL sections below!

PATIENT'S INFORMATION

Sex: ❑ Male ❑ Female

Name: ______________ (last name) ______________ (first name) ______ (initial)

Street address: ______________ (Apt#______) City:__________ State:______ Zip: ________

Home phone: (_______)__________ Date of Birth: ____ (month) / ____ (day) / ____ (year) Social Security # __________

Name of School: ______________

RESPONSIBLE PARTY INFORMATION

Father's Name: ______________ Date of Birth: ____ (month) / ____ (day) / ____ (year) Social Security # __________

Address: ______________ City:__________ State:______ Zip: ________

Home phone: (_____)__________ Work phone: (______)__________ Mobile phone: (______)__________

Employer's Name: ______________ Occupation: __________

Address: ______________ City:__________ State:______ Zip: ________

Mother's Name: ______________ Date of Birth: ____ (month) / ____ (day) / ____ (year) Social Security # __________

Address: ______________ City:__________ State:______ Zip: ________

Home phone: (_____)__________ Work phone: (______)__________ Mobile phone: (______)__________

Employer's Name: ______________ Occupation: __________

Address: ______________ City:__________ State:______ Zip: ________

PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist.

PRIMARY Insurance Company's Name: ______________

Insurance Address: ______________ City:__________ State:______ Zip: ________

Name of Insured: ______________ Date of Birth: __________ Relationship to Insured: ❑ Self ❑ Spouse ❑ Other ❑ Child

Insurance ID Number: ______________ Group Number: __________

SECONDARY Insurance Company's Name: ______________

Insurance Address: ______________ City:__________ State:______ Zip: ________

Name of Insured: ______________ Date of Birth: __________ Relationship to Insured: ❑ Self ❑ Spouse ❑ Other ❑ Child

Insurance ID Number: ______________ Group Number: __________

PATIENT'S REFERRAL INFORMATION

Name of Physician that referred you: ______________

PCP Name (If different than Referring Physician): ______________

EMERGENCY CONTACT

Name of person not living with you: ______________ Relationship: __________

Address: ______________ City:__________ State:______ Zip: ________

Home phone: (_____)__________ Work phone: (______)__________ Mobile phone: (______)__________

PHARMACY PREFERENCE

Name: ______________ Phone: __________