KidstoothDoc

PATIENT REGISTRATION

Patient Name:_____DOB_____

Address:_____ City_____State_____Zip_____

Sex: ◯ Male ◯ Female Age_____ Soc. Sec #:_____ **Medicaid/CHP #**_____

Child's Medical Doctor: _____Phone #_____

Responsible Party

First Name:_____Last Name:_____

Address:_____City_____State_____Zip_____

Home Phone:_____Work:_____Cell:_____Email_____

Birthdate:_____Soc Sec #_____Drivers Lic:_____

Employer:_____Address:_____Phone #_____

Primary Insurance Information (Do not fill out if Primary Insured is Patient)

Name of Insured:_____Relationship to **Patient**: ◯ Parent ◯ Other

Insured Soc Sec #_____ Birthdate :_____Phone # :_____

Address:_____City:_____State:_____Zip_____

Employer:_____Address_____City_____State_____Zip_____

Insurance Company:_____Group #_____

Address:_____City_____State_____Zip_____Phone #_____

Secondary Insurance Information

Name of Insured:_____Relationship to **Patient:** ◯ Parent ◯ Other

Insured Soc Sec #_____DOB:_____Phone # :_____

Address:_____City:_____State:_____Zip:_____

Employer:_____Address:_____City:_____State:_____Zip_____

Insurance Company:_____Group #_____

Address:_____City_____State____Zip_____Phone #_____

EMERGENCY CONTACT other than Parent_____Phone #_____
Relationship to Patient:_____

Other person authorized to bring your child in for treatment:_____
Relationship to Patient:_____

How did you hear about our office:_____

Signature of Responsible party:_____Date:_____