



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:** _____