

CHILD - PATIENT REGISTRATION

Patient's Legal Name: _____ Last 4 Digits S.S. #: _____
(First) (Middle Initial) (Last)

Preferred Name: _____ Marital Status: _____

Gender Identity: _____ Preferred Pronouns: _____

Due to updated Federal guidelines, we are required to obtain specific patient information. Please make sure you answer questions 1-6. Thank you.

(1) Patient's Birthdate: _____ **(2) Patient's Age:** _____ **(3) Sex at Birth:** _____

(4) Race (Check One) Asian **(5) Ethnicity (Check One)** Not Hispanic or Latino **(6) Primary Language (Please List)**
 American Indian/Alaska Native White English
 Native Hawaiian/Other Pacific Island Other Race Hispanic or Latino _____
 African American Declined Declined Declined

Home Address: _____ City: _____ State: _____ Zip Code: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Work #: _____ Cell#: _____

Email: _____

Parent/Guardian 1 Name: _____ DOB: _____ Last 4 Digits S.S. #: _____
(First) (Middle Initial) (Last)

Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____

Employer Name & Address: _____ Occupation: _____

Parent/Guardian 2 Name: _____ DOB: _____ Last 4 Digits S.S. #: _____
(First) (Middle Initial) (Last)

Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____

Employer Name & Address: _____ Occupation: _____

Name of Other: Stepmother Stepfather Grandparent Foster Parent Legal Guardian Power of Attorney

Name: _____ Gender: _____ DOB: _____ Last 4 Digits S.S. #: _____
(First) (Middle Initial) (Last)

Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____

Employer Name & Address: _____ Occupation: _____

PHYSICIAN INFORMATION

Referring Physician: _____ Phone #: _____

Primary Care Physician (If Different): _____ Phone #: _____

Other Provider: _____ Phone #: _____

EMERGENCY CONTACT INFORMATION

Name: _____ **Relation:** _____
(First) (Middle Initial) (Last)
Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
Home #: _____ **Work#:** _____ **Cell #:** _____

PHARMACY INFORMATION

Preferred Pharmacy: _____ **Phone #:** _____
Preferred Mail Order Pharmacy: _____ **Phone #:** _____

INSURANCE INFORMATION

Name of Primary Insurance: _____ **Effective Date:** _____

Subscriber's Name: _____ **Birthdate:** _____
(First) (Middle Initial) (Last)

Policy / Identification # (Include Alpha Prefix, if applicable): _____ **Group #:** _____ **Copay:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Customer Service Phone #: _____ **Relationship to Patient:** _____

Name of Secondary Insurance (If Applicable): _____ **Effective Date:** _____

Subscriber's Name: _____ **Birthdate:** _____
(First) (Middle Initial) (Last)

Policy / Identification # (Include Alpha Prefix, if applicable): _____ **Group #:** _____ **Copay:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Customer Service Phone #: _____ **Relationship to Patient:** _____

Tertiary Insurance (If Applicable) : _____ **Effective Date:** _____

Subscriber's Name: _____ **Birthdate:** _____
(First) (Middle Initial) (Last)

Policy / Identification # (Include Alpha Prefix, if applicable): _____ **Group #:** _____ **Copay:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Customer Service Phone #: _____ **Relationship to Patient:** _____

I acknowledge the above Insurance/Demographic information is correct and that regardless of my insurance status, I am solely responsible for payment of any professional services rendered to me, or on my, behalf, whether or not paid by my insurance company.

 Parent or legally authorized individual signature

 Date

 Printed name if signed on behalf of the patient

 Relationship (parent, legal guardian)