Patient Registration Form

PLEASE PRINT YOUR ANSWERS TO THE FOLLOWING QUESTIONS Today's Date: ________________

PATIENT INFORMATION: (Please use full legal name, no nickname please)
Last Name: _________________________ Frist Name: ____________________ Middle Initial: _____________
SS# _____________________________ Date of Birth: ___________________ Sex: Female [ ] Male [ ]
Race: _____________________________ Ethnicity: Hispanic/Latino [ ] Non-Hispanic/Latino [ ] Decline [ ]
Name your child prefers to be called: ______________________ Preferred Language: _____________________

Mailing Address: ____
City: _____________________________________ State: _________________ Zip: ________________________
Telephone number to best reach you through the daytime: ____
Emergency Contact Name: ______________________________ Emerg Phone #: _________________________
Parent Email address: ____
Preferred Method Contact: [ ]Phone Call [ ] Text Message [ ] Secure Web Message (patient portal)

PARENT INFORMATION:
Mother's First & Last Name: ____ DOB: __________________
Mother's Address (if different than above): ____
City: _____________________________________ State: _______________ Zip: __________________________
Mother's Cell #: ____________________________________ Mother's SSN ______________________________

Father's First & Last Name: ____ DOB: ___________________
Father's Address (if different than above): ____
City: __________________________________ State: __________________ Zip: __________________________
Father's Cell #: ____________________________________ Father's SSN _______________________________
Parent Social Security Numbers are used for ordering labs and sending out referrals, all information is confidential and HIPPA protected

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)
PRIMARY INSURANCE:
Policy Holder's Name: ______________________________ Insurance Name: ____________________________
Policy / ID #: _______________________ Group #: _____________________ Eff Date: ______________________
Employer: ____

SECONDARY INSURANCE:
Policy Holder's Name: ______________________________ Insurance Name: ____________________________
Policy / ID #: __________________________ Group #: __________________ Eff Date: _____________________
Employer: ____

Financial Responsible Party: Mother Father Other ____

A copy of patient's insurance card is requested in addition to completing all information on this form.

Other child(ren) attend the office [ ] Yes [ ] No