Patient Registration Form

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PATIENT INFORMATION

Patient's Last Name:	First:	M.I.:	Birth Date:	Age:	Gender:

Street Address:	City/Town:	State:	Zip:

Social Security No.:	Preferred Language:	Home Phone No. :

Race:	Ethnicity:

PARENT(S) / LEGAL GUARDIAN INFORMATION

Parent / Legal Guardian:	Birth Date:	Relationship to Minor:	Social Security No.:
Address: ☐Check here if same as above	Home Phone No.:	Work Phone No.:	Cell Phone No.:

Marital Status: ☐Married ☐ Single ☐ Divorced ☐ Separated	Custody Status: ☐Joint ☐ Sole ☐ Documents Provided

Parent / Legal Guardian:	Birth Date:	Relationship to Minor	Social Security No.:
Address: ☐Check here if same as above	Home Phone No.:	Work Phone No.:	Cell Phone No.:

Marital Status: ☐Married ☐Single ☐ Divorced ☐ Seperated	Custody Status: ☐Joint ☐Sole ☐ Documents Provided

EMERGENCY CONTACTS (other than parent)

Name:	Relationship:	Home Phone:	Cell/Work Phone:

INSURANCE INFORMATION

Primary Insurance Information

Policy Name:	Policy Number:	Group Number:

Policy Address:	Policy Phone Number:	Copay Amount:

Subscriber's Name:	Birth Date:	Social Security Number:	Relationship to Patient:

Secondary Insurance Information

Policy Name:	Policy Number:	Group Number:

Policy Address:	Policy Phone Number:	Copay Amount:

Subscribers Name:	Birth Date:	Social Security Number:	Relationship to Patient:

Signature of Parent/Legal Guardian: ______________________________________ Date: _______________________