PATIENT REGISTRATION SHEET

(please note a registration form **must** be filled out for **each individual patient**)

FULL LEGAL NAME: ______________________________
(as it appears on birth certificate, including middle initial)

SEX: (M) (F) DATE OF BIRTH: ______________ WHO DOES CHILD RESIDE WITH? ______________

ADDRESS: ______________ MAILING ADDRESS: ______________
(where child is living, not a P.O. Box, include any apartment #) (if different)

CITY: ______________ STATE: ______________ ZIP CODE: ______________

PREFERRED PHONE: ______________ ALTERNATE PHONE: ______________

EMERGENCY CONTACT OTHER THAN PARENT: ______________________________
(NAME AND PHONE NUMBER)

PARENTS INFORMATION:

IF NOT MARRIED, Who Has Custodial Rights: ❑ Mother ONLY ❑ Father ONLY ❑ Both Parents

❑ Other ______________

PARENT NAME: ______________
Relationship: father, mother, legal guardian, other

ADDRESS: ______________
(if different from child, include city, state and zip)

SS#: ______________ BIRTHDATE: ______________

EMAIL: ______________ CELL# ______________

EMPLOYER: ______________ WORK# ______________

MAY WE CALL YOU AT WORK? YES ___ NO ___

PARENT NAME: ______________
Relationship: father, mother, legal guardian, other

ADDRESS: ______________
(if different from child, include city, state and zip)

SS#: ______________ BIRTHDATE: ______________

EMAIL: ______________ CELL# ______________

EMPLOYER: ______________ WORK# ______________

MAY WE CALL YOU AT WORK? YES ___ NO ___

INSURANCE INFORMATION:

PRIMARY INSURANCE NAME: ______________

POLICY HOLDER: ______________

DATE OF BIRTH: ______________

EMPLOYER: ______________ SS# ______________

RELATIONSHIP TO INSURED: ______________
(CHILD, STEPCHILD, OTHER, PLEASE SPECIFY)

POLICY ID# ______________

GROUP # ______________ EFFECTIVE DATE: ______________

SECONDARY INSURANCE NAME: ______________
(IF APPLICABLE)

POLICY HOLDER: ______________

DATE OF BIRTH: ______________

EMPLOYER: ______________ SS# ______________

RELATIONSHIP TO INSURED: ______________
(CHILD, STEPCHILD, OTHER, PLEASE SPECIFY)

POLICY ID# ______________

GROUP # ______________ EFFECTIVE DATE: ______________

PLEASE COMPLETE BOTH SIDES

PLEASE LIST SIBLINGS WHO ARE CURRENTLY PATIENTS IN OUR PRACTICE:

NAME:______________________________ DOB:______________________ lives with patient listed above: Y or N

______________________________ ______________________ lives with patient listed above: Y or N

______________________________ ______________________ lives with patient listed above: Y or N

______________________________ ______________________ lives with patient listed above: Y or N

FAMILY MEDICAL HISTORY

Check if any blood relative (parents, grandparents, brothers, sisters, aunts, uncles) have any of the following:

______ Asthma	______ Migraines	______ High Blood Pressure
______ High Cholesterol	______ Diabetes	______ Seizures (Epilepsy)
______ Thyroid	______ Heart Problem	______ Emotional/Psychiatric
______ Allergies	______ Cancer	______ Anemia
______ Neurological	______ Lung Disorders	______ Kidney Disease
______ Eye/Vision Problems	______ Hearing Problems	______ Scoliosis
______ Birth Defects	______ Arthritis	

Please list any other family medical history you feel is pertinent to your child's care:

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FORM COMPLETED BY:______________________ RELATIONSHIP TO PATIENT:______________________

DATE: ________________