



Date Completed:
Primary Care Provider

Patient Registration Form (Please fill in all fields completely)

Patient Information

Child's Full Legal Name (Last, First, Middle)	Date of Birth	Sex	Preferred Name
Other Children in family:			
Child's Street Address (City, State, Zip Code)	Telephone# where child lives	Parent Work # <input type="checkbox"/> Mom <input type="checkbox"/> Dad	Parent Email Address: <input type="checkbox"/> Mom <input type="checkbox"/> Dad
Patient's Race: White ___ African American ___ Hispanic ___ Native American ___ Asian ___ Other ___ Refused ___			
Patient's Primary Language: English ___ Spanish ___ Asian ___ Other _____			
Parent's/Legal Guardian's Primary Language: English ___ Spanish ___ Asian ___ Other _____			
Does the parent/legal guardian require an interpreter? Yes <input type="checkbox"/> No <input type="checkbox"/>			

If there is insurance for child/children, please present the insurance card to the check-in staff.

Emergency Contacts

Mother's Name (Last, First, Middle)	Home #	Work #	Cell #
Home Address (City, State, Zip Code) (if different from above)			
Father's Name (Last, First, Middle)	Home #	Work #	Cell #
Home Address (City, State, Zip Code) (if different from above)			
Additional Contact (Last, First, Middle)	Home #	Work #	Cell # (Relationship to Patient)
Home Address (City, State, Zip Code)			
Who may we thank for referring you to our practice?			Birth Hospital (Newborn's Only)

Guarantor Information (Person financially responsible)

Name	Relationship to Patient	Emancipated Minor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Street Address (If different from patient)	City	State	Zip
Date of Birth	Home#	Work#	Cell #
Employer Name	City	State	Zip

Insurance Information (if the insurance is provided, please complete the information below)

Insurance Name	Claims Address	Telephone #
Subscriber ID#	Group #	Patient Relationship to Subscriber:
Subscriber's Name	DOB:	
Subscriber Address (if different than guarantor)	Subscriber Employer	