PATIENT REGISTRATION FORM

Patient: Last Name _____ First Name _____ M.I. ____ DOB _____

Gender M F Race _____ Ethnicity _____

Appointment Reminders:

Email Address _____ Phone Number _____

☐ Sign-up for EMAIL reminders
☐ Sign-up for TEXT reminders
☐ Sign-up for VOICE CALL reminders

Emergency Contact (other than parents):

Last Name _____ First Name _____

Phone _____ Relationship to the Patient _____

Parent/Legal Guardian Information:

Mother Father Foster Other _____

Last Name _____ First Name _____ M.I. ____

DOB _____ Social Security Number _____ Primary Phone _____

Secondary Phone _____ Street Address _____

City _____ State _____ Zip Code _____

Employer _____ Employer's Phone Number _____

Other Parent/Legal Guardian Information:

Mother Father Foster Other _____

Last Name _____ First Name _____ M.I. ____ DOB _____

Social Security Number _____ Primary Phone _____

Secondary Phone _____ Street Address _____

City _____ State _____ Zip Code _____

Employer _____ Employer's Phone Number _____

Insurance Information:

Insurance Company Name _____ Policy Holder Name _____

Subscriber/Policy Number _____ Policy Group Number _____

Policy Holder Information (only if the policy holder is not parent/legal guardian):

Last Name _____ First Name _____ M.I. ____

DOB _____ Social Security Number _____ Home Phone _____

Cell Phone _____ Street Address _____

City _____ State _____ Zip Code _____ Employee _____

Employer Phone Number _____