Patient Registration Form

Patient Last Name:____First:__________________________________MI:_______

Date of Birth: ________/_______/__________ Sex: M / F Gender Identity: M / F

Race: ___________________________ Language: ___________________________ Ethnicity: Hispanic / Non-Hispanic

Address:____

City/State/Zip: ____

Contact Telephone #:________/_______/__________ ☐ CELL ☐ LANDLINE

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Primary Guardian: Father / Mother / Legal Guardian **(please circle one)** Employer:_______________________

***Primary contact will receive appointment reminders and be the patients address and phone information on the account.**

Name:____ Date of Birth: ______/_______/____________

☐ **Same as above please check** Address: ____

Telephone #:________/_______/__________ ☐ CELL ☐ LANDLINE

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Secondary Guardian: Father / Mother / Legal Guardian **(please circle one)** Employer:_______________________

Name:____ Date of Birth: _______ /_______/___________

Address: ____

Telephone #:________/_______/__________ ☐ CELL ☐ LANDLINE

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Emergency Contact:

Name:____ Relationship:_____________________________

Telephone #:________/_______/__________ ☐ CELL ☐ LANDLINE

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Insurance Information:

Primary Carrier:____Subscriber Name:____________________________________

Secondary Carrier:____Subscriber Name:____________________________________

If you need to have someone bring in your child for appointments and/or get account information you **MUST fill out and sign the *Consent for Medical Treatment* form. Please ask us for this form. Thank you.