



Patient Registration Form
Welcome to our office!

Today's Date: _____

Please complete the following form and bring it the front desk with your insurance card and co-payment. Co-Payment and any past-due balance are expected at the time of service.

Child's Full Name: _____ Preferred Name: _____
Date of Birth: ____/____/____ Male ___ Female ___ SSN: _____

Address of Child: _____ Phone No. _____ - _____ - _____
City _____ State _____ Zip Code _____
Emergency Contact: Name _____ Phone No. _____ - _____ - _____

We will have the ability to send educational and informational materials to you by email in the near future. Please indicate your preferred email address for such here: _____

Mother's Name or Primary Guardian: _____
Biological Mother ___ Step-mother ___ Foster Mother ___ Other: _____
Date of Birth: ____/____/____ SSN: _____
Email: _____
Employer: _____ Job Title: _____
Work number _____ - _____ - _____ Mobile Number _____ - _____ - _____
If address is different from child please indicate here: _____
If phone number is different from child please indicate here: _____ - _____ - _____

Father's Name or Secondary Guardian: _____
Biological Father ___ Step-father ___ Foster father ___ Other _____
Date of Birth ____/____/____ SSN: _____
Email: _____
Employer: _____ Job Title: _____
Work number _____ - _____ - _____ Mobile Number _____ - _____ - _____
If address is different from child please indicate here: _____
If phone number is different from child please indicate here: _____ - _____ - _____

Primary Insurance Information:
Name of Insured: _____ Date of Birth: ____/____/____
SSN: _____ Insurance Company _____
Group # _____ Policy/ID/Member # _____ Co-pay _____

Secondary Insurance Information:
Name of Insured: _____ Date of Birth ____/____/____
SSN: _____ Insurance Company _____
Group # _____ Policy# _____ Co-pay _____

<p>Office use only: Date received: _____ Date recorded: _____ Completed by: _____</p>
