



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: _____

For federal requirements, we request the following information; please choose only ONE each:

Race: ___ African-American ___ American Indian ___ Asian ___ Caucasian/White

___ Hispanic ___ Native Hawaiian ___ Pacific Islander ___ Other ___ Decline to Provide

Ethnicity (Heritage, f.ex. American, Costa Rican, Vietnamese): _____

Preferred Language: _____

Address of Child: _____ Phone No. _____-_____-_____

City _____ State _____ Zip Code _____

Emergency Contact: Name _____ Phone No. _____-_____-_____

If we need to email information for this patient, please indicate the preferred email address (generally a parent's email) for this patient: _____

Preferred Contact Method: ___ Mail ___ Email ___ Phone # Above ___ Mom's Cell ___ Dad's Cell

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 _____

**Office Use
ONLY**

Date rec'd:
____/____/____

Date entered:
____/____/____

Completed by: