Patient Registration (Please Print Clearly)

Name: ____________________ Date of Birth ___/___/___Sex: M/F

Name: ____________________ Date of Birth ___/___/___Sex: M/F

Name: ____________________ Date of Birth ___/___/___Sex: M/F

Name: ____________________ Date of Birth ___/___/___Sex: M/F

Primary Cell Phone Number: ____________________Secondary Phone Number: ____________________

Family Email Address: ____________________

Billing Address:____________________

City: ____________________State: ______________Zip Code: ____________________

Guardian 1: ____________________ Date of Birth _____/_____/_____

Relationship to child: ____________________ Guardian's Occupation: ____________________

Guardian 2: ____________________ Date of Birth _____/_____/_____

Relationship to child: ____________________ Guardian's Occupation: ____________________

Insurance information: ***Front Desk Staff is required to see each child's insurance card at each visit!***

Parent Responsible for insurance: Mother _________ Father__________ Other ________

Insurance Company____________________ID#____________________Guarantor SSN: ______________

OTHER THAN PARENT

Name & Relationship of others who have permission to bring & are authorized to make medical decisions for your child/children and will be your emergency contact if we can not reach you.

Name: ____________________ Relationship: ______________ Phone #: ____________________

Name: ____________________ Relationship: ______________ _Phone #: ____________________

Parent/Guardian Print Name: ____________________

Parent/ Guardian Signature: ____________________ Date:____________________