Date Completed	
Primary Care Provider	

Patient Registration Form (Please fill in all fields completely)

Patient Information

Child's Full Legal Name (Last, First, Middle)	Date of Birth (MM/DD/YEAR)	Sex ☐Female ☐Male	S.S #
Other Children in family:			
Child's Mailing Address (City, State, Zip Code)	Telephone# where child lives	Parent's Work # ☐ Mom ☐ Dad	Parent's Email Address: ☐ Mom ☐ Dad

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian and other Pacific Islander ☐ White ☐ Other

Ethnic Group: ☐ Hispanic ☐ Non-Hispanic ☐ Other

Patient's Primary Language: English ____ Spanish ____ Other _____

Parent's/Legal Guardian's Primary Language: English ____ Spanish ____ Other _____

Emergency Contacts

Mother's Name (Last, First, Middle)	S.S #	Work #	Cell #
Home Address (City, State, Zip Code) (if different from above)			
Father's Name (Last, First, Middle)	S.S #	Work #	Cell #
Home Address (City, State, Zip Code) (if different from above)			
Additional Contact (Last, First, Middle)	Home #	Work #	Cell # (Relationship to Patient)
Home Address (City, State, Zip Code)			
			Birth Hospital

Guarantor Information (Person financially responsible)

Name	Relationship to Patient		
Street Address (If different from patient)	City	State	Zip
Date of Birth	Home #	Work #	Cell #
Employer Name	City	State	Zip

Insurance Information

Insurance Name	Claims Address	Telephone #
Subscriber ID #	Group #	Relationship to Patient:
Subscriber's Name		DOB:
Subscriber Address (if different than guarantor)		Subscriber Employer