

THIS IS A PERMANENT LEGAL DOCUMENT

REGISTRATION INFORMATION

TODAY'S DATE

PATIENT INFORMATION (PLEASE PRINT FULL LEGAL NAMES)

LAST NAME		FIRST		MIDDLE		PHONE (AREA CODE) ()	
STREET ADDRESS				CITY		STATE	ZIP CODE
BIRTH DATE	AGE	SEX (CIRCLE ONE) M F	WITH WHOM DOES THE CHILD LIVE?		CELL OR PAGER #		
E-MAIL ADDRESS				IS THE CHILD?		<input type="checkbox"/> ALASKAN NATIVE <input type="checkbox"/> AMERICAN NATIVE	
FATHER'S NAME		ADDRESS			HOME #	WORK #	EXT.
MOTHER'S NAME		ADDRESS			HOME #	WORK #	EXT.
STEP PARENT OR OTHER GUARDIAN		ADDRESS			HOME #	WORK #	EXT.

PERSON RESPONSIBLE FOR BILLING (Who carries Insurance?)

LAST NAME		FIRST		MIDDLE		BIRTH DATE	PHONE (AREA CODE)
STREET ADDRESS				CITY		STATE	ZIP CODE
EMPLOYER	WORK PHONE		SOC. SECURITY NUM.		RELATIONSHIP TO PATIENT		
SPOUSE'S EMPLOYER			WORK PHONE		SOCIAL SECURITY NUMBER		

HEALTH INSURANCE (CIRCLE ONE)

AETNA		ANTHEM/BLUE CROSS		CIGNA		FIRST HEALTH		MEDICAID		MMA		ONE HEALTH		PACIFICARE		PHCS	
SLOANS LAKE				UNITED HEALTH CARE				OTHER									
INSURANCE COMPANY NAME				COPAY		GROUP#		SUBSCRIBER'S I.D. NUMBER									
INSURANCE COMPANY BILLING ADDRESS						CITY		STATE	ZIP CODE								

REFERRED BY:

NAME	OTHER CHILDREN IN THE PRACTICE? <input type="checkbox"/> YES <input type="checkbox"/> NO
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PERSON TO CONTACT IN CASE OF EMERGENCY (NOT LIVING WITH YOU)

NAME		HOME PHONE	WORK PHONE
ADDRESS		CITY	STATE ZIP CODE

PATIENT'S DAYCARE, SCHOOL, COLLEGE OR EMPLOYMENT

NAME		PHONE
ADDRESS		CITY STATE

ALLERGIES (LIST MEDICATION & OTHER SUBSTANCES TO WHICH PATIENT IS ALLERGIC)

NONE <input type="checkbox"/> YES <input type="checkbox"/> EXPLAIN:	FOR OFFICE USE ONLY VISITOR <input type="checkbox"/>
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In that my son/daughter is a minor (less than eighteen) (18) years of age and primarily supported by parent or guardian), I agree and understand that he/she may be treated by any provider associated here. This may include physical and gynecological exams, blood and urine tests, x-rays, minor surgery, immunizations, and prescription medications in my absence. This agreement will be in effect until revoked by me in writing.

SIGNATURE OF PARENT OR GUARDIAN	WITNESS	DATE
SIGNATURE OF PATIENT	WITNESS	DATE

FOR OFFICE USE ONLY

CHANGE OF ADDRESS	PHONE
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