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? ☐ ALASKAN NATIVE ☐ 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 COVENTRY MEDICAID ONE HEALTH PACIFICARE PHCS
COFINITY 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? ☐ YES ☐ NO

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 ☐ YES ☐ EXPLAIN:	FOR OFFICE USE ONLY VISITOR ☐

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