Please fill out all the information asked for

Patient Registration:

Last Name:_________________________ First Name:___________________________ MI:________
D.O.B:______/______/______ Sex:____ Primary Language Spoken:__________________________
Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White
State where patient was born:____________________________
Hospital where patient was born: ____________________ Name of OBGYN:____________________

Mailing Address:

____
Street or PO Box City State & Zip Code
Home Phone: (____) ______-_______ Cell Phone: (____) _____-_______

Insurance:

Primary Policy: Policy Holder's Name:____
Policy Holder's Birth Date: _____/_____/_____ Policy Holder's Sex: Male / Female
Insurance Carrier:_____________________________ Policy Holder's SSN: ________________________

Secondary Policy: PolicyHolder'sName:____
Policy Holder's Birth Date: _____/_____/_____ Policy Holder's Sex: Male / Female
Insurance Carrier:_____________________________ Policy Holder's SSN: ________________________

Contact 1:

Name: ____________________________ Relationship to Patient:__________________________
Lives with Patient: Yes / No Date of Birth: ____/____/____ SSN #: _____/____/_____
Home Phone: (____) _____-______ Cell Phone: (____) _____-______
Home Email: ____
Employer: ____________________________________ Occupation: ___________________________
How would you ideally prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Cell Phone / Home Email
Appointment Reminders: Home Phone / Cell Phone / Home Email
Recall Notices: Home Phone / Cell Phone / Home Email
Billing Statements: Home Phone / Cell Phone / Home Email
General Practice Notice: Home Phone / Cell Phone / Home Email

Contact 2:

Name: ____________________________ Relationship to Patient:__________________________
Lives with Patient: Yes / No Date of Birth: ____/____/____ SSN #: _____/____/_____
Home Phone: (____) _____-______ Cell Phone: (____) _____-______
Home Email: ____
Employer: ____________________________________ Occupation: ___________________________

Continuation…..

If this contact will need to be notified in addition to Contact 1 for Medical Issues, Appointment Reminders, Recall Notices, Billing Statements, General Practice Notices list their preferences here:____
____

Additional Contact Questions:

Who should receive billing statements?____
May all contacts have access to the patient's records electronically (when available)? Yes / No______

If parents are divorced or separated please fill out this section:

*Who has custody?*____
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.
____
____

Emergency Contacts, other than parents:
Name & Relationship
1:_______________________________________ Phone: (____) _____-_______
2:_______________________________________ Phone: (____) _____- _______

Whom may we thank for referring the patient to us:
[ ] Insurance:________________________ [ ] Family Member:___________________________
[ ] Doctor:__________________________ [ ] Money Saver [ ] Church: _____________________
[ ] Flyer [ ] Internet: ________________________ [ ] Other: ____________________________