

REGISTRATION

CHART # _____

PLEASE PRINT

DATE _____ REFERRED BY: _____ CHILDS NAME _____

1. INFORMATION REGARDING PATIENT:

FIRST NAME _____ MIDDLE INIT _____ LAST NAME _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE: HOME () _____ FAMILY EMAIL ADDRESS: _____

DATE OF BIRTH _____ AGE _____ SS # _____ MALE FEMALE

SIBLINGS: _____ BIRTHDATE: _____

2 A: PARENT/ LEGAL GUARDIAN (CIRCLE APPROPRIATE RELATIONSHIP)

LAST NAME _____ FIRST NAME _____ MI _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE () _____ WORK () _____ CELL () _____

PLACE OF EMPLOYMENT _____ OCCUPATION _____

RELATION TO PATIENT _____ DATE OF BIRTH _____ SS # _____

B. SPOUSE / NEAREST RELATIVE

LAST NAME _____ FIRST NAME _____ MI _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE () _____ WORK () _____ CELL () _____

PLACE OF EMPLOYMENT _____ OCCUPATION _____

RELATION TO PATIENT _____ DATE OF BIRTH _____ SS # _____

3 INFORMATION REGARDING INSURANCE THAT COVERS PATIENT:

INSURANCE NAME _____

INSURED NAME _____ INSURED ADDR _____

POLICY # _____ GROUP # _____ INSURED ADDR _____

RELATION TO PATIENT _____ CITY _____ ST _____ ZIP _____

DATE OF BIRTH OF INSURED _____ PHONE - INSURANCE CO () _____

SS # _____ COMPANY NAME _____

I authorize medical treatment and payment of medical benefits to the physician for service. I assume all responsibility for charges. I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original.

Signature_____
Date

