Child/Dependent Registration Form

Account No.	Entered Date
Reg. By	Office Site
☐ New ☐ Change	Info. Change:

Please complete this form in order to ensure proper billing of your services. **Please Print.** Today's Date: ______________

Patient Information

Patient Last Name: ______________________________

First Name: ______________________ MI: ________

Other Name/AKA: ______________________________

Addr1: ______________________________

Addr2: ______________________________

City, State, Zip: ______________________________

Preferred Method of Contact:
☐ Alt Phone Number ☐ Email ☐ Letter
☐ Phone Call (Cell) ☐ Phone Call (Home)

Employment Status:
☐ Employed Full Time ☐ Employed Part Time ☐ Student

Employer: ______________________________

Social Security Number: ______________________________

Date of Birth: __________________ Sex: ☐ M ☐ F

Home Phone: (________) ______________________

Alt Phone: (________) ______________________

Cell Phone: ______________________________

Email Address: ______________________________

Ethnicity: **(Data is used for statistical reporting.)**
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient Declined

Race: **(Data is used for statistical reporting.)**
☐ American Indian or Alaska Native ☐ Black or African American
☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ White
☐ Patient Declined

Language: ☐ English ☐ Spanish ☐ Other ______________

Insurance Information

(A separate form is required for worker's compensation, automobile liability, or legal services.)

PRIMARY CARRIER: ______________________________

Address: ______________________________

Subscriber's Name: ______________________________

Subscriber's DOB: __________________ Sex: ☐ M ☐ F

Subscriber's Employer: ______________________________

Telephone #: (________) ______________________

Child's ID: ______________________________

Group/Plan #: ________________ Effective Date: ________

Subscriber SS#: ________ Relationship to Patient: ________

PCP listed on Card: ______________________________

SECONDARY CARRIER: ______________________________

Address: ______________________________

Subscriber's Name: ______________________________

Subscriber's DOB: __________________ Sex: ☐ M ☐ F

Subscriber's Employer: ______________________________

Telephone #: (________) ______________________

Child's ID: ______________________________

Group/Plan #: ________________ Effective Date: ________

Subscriber SS#: ________ Relationship to Patient: ________

PCP listed on Card: ______________________________

Primary Care Phys.: ______________________________

Address: ______________________________

City, St., Zip: ______________________________

Telephone #: (________) ______________________

Refer. Phys. (if different): ______________________________

Address: ______________________________

City, St., Zip: ______________________________

Telephone #: (________) ______________________

Pharmacy Name, Address & Phone #: ____

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Guarantor Information
(Guarantor is the person financially responsible for this patient's bill.)

Guarantor: ____________________ Patient's Relationship to Guarantor: ____________________

Addr1: ____________________ Social Security Number: ____________________

Addr2: ____________________ Date of Birth: ____________________ Sex: ☐ M ☐ F

City, State, Zip: ____________________ Home Phone: (________) ____________________

Employer: ____________________ Work Phone: (________) ____________________

Address: ____________________ Cell Phone: (________) ____________________

City, State, Zip: ____________________ Email Address: ____________________

Driver's License # ____________________ State __________

Other Parent or Guardian

Parent/Guardian: ____________________ Patient's Relationship to Guarantor: ____________________

Addr1: ____________________ Social Security Number: ____________________

Addr2: ____________________ Date of Birth: ____________________ Sex: ☐ M ☐ F

City, State, Zip: ____________________ Home Phone: (________) ____________________

Employer: ____________________ Cell Phone: (________) ____________________

Address: ____________________ City, State, Zip: ____________________

Work Phone: (________) ____________________ Driver's License # ____________________ State __________

Emergency Contact Information
(Someone living outside the primary household.)

Last Name, First Name: ____________________ Patient's Relationship to Contact: ____________________

Addr1: ____________________ Home Phone: (________) ____________________

Addr2: ____________________ Work Phone: (________) ____________________

City, State, Zip: ____________________ Cell Phone: (________) ____________________

List All Children/Siblings

Child #1 Last Name	First Name	Date of Birth
Child #2 Last Name	First Name	Date of Birth
Child #3 Last Name	First Name	Date of Birth
Child #4 Last Name	First Name	Date of Birth

How did you hear about our practice? ☐ Billboard ☐ Brochure ☐ Health Fair ☐ Health Plan ☐ Internet ☐ Mass Mailing

☐ Newspaper/Magazine ☐ Ongoing Care ☐ Patient ☐ Phone Book ☐ Phys. Off/ER ☐ Relative ☐ Radio ☐ TV ☐ Word of Mouth ☐ Other