Patient Registration

Name: Preferred Contact#:

(Last, First, Middle) Mother Father Other Gender: Date of Birth: Social Security #:

Race/Ethnicity: Religion (Optional):

Primary Home Address:

City: State: Zip:

Email: Home Phone:

Resides with: Relationship:

# Mother’s Information

Name: Cell: (Last, First, Middle)

Social Security #: Date of Birth:

Address: (Check if same as child) City: State: Zip: Email: Home#:

Employer: Work#:

Insurance Subscriber Financially Responsible Party:

Insurance Name: ID# Group#:

# Father’s Information

Name: Cell: (Last, First, Middle)

Social Security #: Date of Birth:

Address: (Check if same as child) City: State: Zip: County: Home#:

Employer: Work#:

Insurance Subscriber Financially Responsible Party:

Insurance Name: ID# Group#:

# Sibling’s Information

Name: Date of Birth:

Name: Date of Birth:

Name: Date of Birth:

Name: Date of Birth:

# Emergency Contact Information

Name: Relationship: (Last, First, Middle)

Home Phone: Work Phone:

# Emergency Contact Information

Name: Relationship: (Last, First, Middle)

Home Phone: Work Phone:

# Coordination of Benefits Notification:

Coordination of benefits (COB) allows the plans that provide health coverage for your child to determine which insurance plan has the primary payment responsibility and how other plan(s) will contribute when your child is covered by more than one plan. If your child is covered by more than one plan, you may need to contact each plan from time to time to update coordination of benefits. This is the responsibility of the guarantor on the individual insurance policies. If you receive a request from your insurance company to update coordination of benefits, please do so in a timely manner as to not hold up the processing of your child's medical claims.

Please present all insurance information to the receptionist so we can properly bill for your child's medical services. We need to have a copy (front and back) of the insurance cards on file.

***Form Completed By: Date:***