



## CHILD PATIENT REGISTRATION FORM

(Please Print Clearly)

<b>Today's Date:</b>				
<b>CLIENT INFORMATION</b>				
<b>Last Name:</b>	<b>First:</b>	<b>Middle:</b>	<input type="radio"/> Male	<input type="radio"/> Female
<b>Address:</b>			<b>Apt#:</b>	
<b>City:</b>	<b>State:</b>	<b>Zip:</b>		
<b>Home Phone:</b> (    )	<b>Social Security no.:</b>			
<b>Birth date:</b>	<b>Age:</b>	<b>Birth Place:</b>		
<b>School:</b>			<b>Grade:</b>	
<b>Is student living with both natural parents?</b> <input type="radio"/> Yes <input type="radio"/> No If no, please explain: (Adoption, divorce, death, etc.)				
<b>Present Mother:</b>		<b>Social Security no.:</b>		
<b>Mother phone no.:</b> (    )		<b>Mother cell no.:</b> (    )		
<b>Address</b> (If different from child):				
<b>Are you employed?</b> <input type="radio"/> Yes <input type="radio"/> No		<b>Occupation:</b>		
<b>Present Father:</b>		<b>Social Security no.:</b>		
<b>Father phone no.:</b> (    )		<b>Father cell no.:</b> (    )		
<b>Address</b> (If different from child):				
<b>Are you employed?</b> <input type="radio"/> Yes <input type="radio"/> No		<b>Occupation:</b>		
<b>Who referred you to our office?:</b>				
<b>Who is financially responsible for this bill?</b>				
<b>I will be paying today by:</b> <input type="radio"/> Cash <input type="radio"/> Cheque <input type="radio"/> Credit Card <input type="radio"/> Debit Card				



**INSURANCE INFORMATION**

(Please give your insurance card to the receptionist.)

**Person responsible for bill:**

**Birth date:**

**Address (if different):**

**Home phone no.:** ( )

**Is this person a patient here?**  Yes  No

**Occupation:**

**Employer:**

**Employer address:**

**Employer phone no.:** ( )

**Is this patient covered by insurance?**  Yes  No

**Please indicate primary insurance:**  Insurance  Welfare (Please provide coupon)  Other

**Subscriber's name:**

**Subscriber's S.S. no.:**

**Birth date:**

**Group no.:**

**Policy no.:**

**Co-payment:** \$

**Patient's relationship to subscriber:**  Self  Spouse  Child  Other

**Name of secondary insurance (if applicable):**

**Subscriber's name:**

**Group no.:**

**Policy no.:**

**Patient's relationship to subscriber:**  Self  Spouse  Child  Other

**IN CASE OF EMERGENCY**

**Name of local friend or relative (not living at same address):**

**Relationship to patient:**

**Home phone no.:** ( )

**Work phone no.:** ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

**Patient/Guardian signature**

**Date**