Patient Registration Form

Patient Information:

Name: _____Date of Birth: _____

Sex: _____Preferred Language: _____Race/Ethnicity: _____

Siblings:

Name	Date of Birth	Male/Female

Parent Information:

Parent 1 Name :_____Date of Birth:_____

Address: _____

Home phone _____ Cell_____work_____

Occupation: _____Employer: _____

Email: _____ Live with patient: Yes / No

Parent 2 Name: _____Date of Birth: _____

Address: _____

Home phone _____ Cell_____work_____

Occupation: _____Employer: _____

Email: _____ Live with patient: Yes / No

Preferred mode of communication? (circle) EMAIL TEXT HOME CELL

Primary Insurance: _____Secondary Insurance:_____

Policy Holder Name_____Employer_____

DOB_____ID#_____Group #_____

- If parents divorced or separated or unmarried who has custody:_____Are there any legal restrictions to medical care? If yes please explain and provide legal documentation to restrictions:_____

Pharmacy Name/location_____

Signature_____Print_____Date_____