



# Lewiston Village Pediatrics Patients Registration

CHILDREN'S NAME	DATE OF BIRTH	RACE	HISPANIC OR LATINO	LANGUAGE

## PARENTS/RESPONSIBLE PARTY INFORMATION

Parent #1 Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Parent #2 Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

EMAIL Address: \_\_\_\_\_

## FOR OUR NEW PATIENTS TO THE OFFICE

Who referred you? How did you hear about us? \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION (Other than parents of child)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ hone: \_\_\_\_\_

**A \$40.00 FEE WILL BE CHARGED FOR MISSED APPOINTMENTS NOT CANCELLED WITHOUT 24 HOUR NOTICE**

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_