



# PATIENT REGISTRATION FORM (MINOR)

<b>OFFICE USE ONLY</b>	
NG Account # _____	
MM Account # _____	

Name \_\_\_\_\_  male  female

Address \_\_\_\_\_ Apt# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Student:  yes  no School Name \_\_\_\_\_

Child lives with:  both parents  mother  father  other \_\_\_\_\_

Guardian's Name \_\_\_\_\_

Mother's Name \_\_\_\_\_

(If Different) Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employed:  yes  no Employer \_\_\_\_\_

Father's Name \_\_\_\_\_

(If Different) Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employed:  yes  no Employer \_\_\_\_\_

May we leave messages at home with other residents	<input type="checkbox"/> yes	<input type="checkbox"/> no
May we leave personal health information on your answering machine/voicemail	<input type="checkbox"/> yes*	<input type="checkbox"/> no
May we contact you via e-mail or cellular telephone	<input type="checkbox"/> yes**	<input type="checkbox"/> no
<i>*Appointment reminders will be left on voicemail.</i>		
<i>**We cannot ensure the confidentiality of information shared by these means.</i>		
Who may we contact in case of Emergency? Name _____		
Relationship _____	Phone #1 _____	#2 _____
Who may we talk to about your child's medical concerns?		
<b>Note:</b> Unless we have legal documents on file restricting access to medical information, both parent's have the right to access a child's medical record. However, we cannot give any info personal health information to anyone other than a parent unless you list him or her by name.		
Name _____	Relationship _____	

## INSURANCE INFORMATION

**Note:** We require that your card be presented at every visit ~ OR~ if card is not available you must verify eligibility, and provide ID#, group #, mailing address & provider services #. If not, you will be responsible for the cost of the office visit.

Primary Insurance Company \_\_\_\_\_ Co-payment \$ \_\_\_\_\_

Card Holder Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relationship to card holder:  self  mother  father  other

Secondary Insurance _____		
Card Holder Name _____	Birth Date _____	
Address _____	Social Security # _____ - _____ - _____	
Relationship to Card Holder: <input type="checkbox"/> self <input type="checkbox"/> mother <input type="checkbox"/> father <input type="checkbox"/> other		
Card(s) Copied: Primary: <input type="checkbox"/> yes <input type="checkbox"/> no      Secondary: <input type="checkbox"/> yes <input type="checkbox"/> no		

I understand that when I sign this document that I am confirming that all information completed by me is correct and that any falsification can lead to my dismissal from this practice.

Signature \_\_\_\_\_ Today's Date \_\_\_\_\_

## HOW DID YOU HEAR ABOUT US?

- 411
- HealthCALL
- Newspaper
- Referring Physician \_\_\_\_\_
- Brochure
- Insurance Listing
- Radio
- Other \_\_\_\_\_
- Drive-By Signage
- Phone Book
- Shopping Cart
- Family or Friends
- Postcard
- Website