PATIENT REGISTRATION (PEDIATRIC) (For minors only; to be completed by parent or guardian only)

Today's Date: ____________________

Child's Name: ______________________________ DOB: _____/_____/_____
First Middle Last

Name child prefers to be called: ____________________ Age: __________ Sex: M F (circle)

Mother's Name: ______________________________ DOB: _____/_____/_____
First Middle Last

Mother's Occupation and Employer (if applicable): ______________________________

Father's Name: ______________________________ DOB: _____/_____/_____
First Middle Last

Father's Occupation and Employer (if applicable): ______________________________

Names and ages of siblings: ______________________________
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Mailing Address: ______________________________

City: ____________________ State: __________ Zip: __________

Home Phone: ____________________ Work Phone: ____________________

Mother's Cellphone: ____________________ Father's Cellphone: ____________________

Best email address to use: ____________________ @ ____________________

Do you have Medical Insurance? ☐ No ☐ Yes (If yes, please give your information to the staff.)

→ We are happy to file insurance for you as a courtesy.

→ Regardless of your insurance status, you are ultimately responsible for the balance on your account for professional services rendered or products purchased.

Who referred your child to our clinic? ______________________________