**PATIENT REGISTRATION** (PLEASE PRINT)  **□ Update Year: 2018**

# PATIENT INFO

**Patient’s Name**

LASTFIRSTMIDDLESOCIAL SECURITY **#**

**Date of Birth** **Age**  **Sex** **□ Male** **□ Female**

**Child lives with**:  **□** Mom & Dad **□** Primarily Mom **□** Primarily Dad **□** Other

**Primary Home Address**  **□ Mom** **□ Dad**

STREET CITY STATE ZIP

**Secondary Home Address**  **□ Mom** **□ Dad**

STREET CITY STATE ZIP

**Mom’s Name** **Home Phone** **Cell Phone**

**Dad’s Name** **Home Phone** **Cell Phone**

**Emergency Contact Home Phone Cell Phone**

**======================================================================================================**

Parent/Guardian info

**Responsible Party**

LASTFIRSTMIDDLESOCIAL SECURITY **#**

**Employer** **Occupation**

**Work Phone #**   **Driver’s License Number**

**Other Parent Name:**

LASTFIRSTMIDDLESOCIAL SECURITY **#**

**Other Parent Employer** **Occupation**

**Work Phone #**   **Driver’s License Number**

**Email Address**  **Pharmacy**

## INSURANCE INFO

**======================================================================================================**

**Primary Insurance Insured’s Name**

**Through which employer?**  **Date of Birth**

**Address** **Insurance ID #**

**Group #**

CITY STATE ZIP

**Secondary Insurance Insured’s Name**

**Through which employer?**  **Date of Birth**

**Address** **Insurance ID #**

**Group #**

CITY STATE ZIP

**======================================================================================================**

**CONSENT**

I hereby give consent for medical or surgical treatment to the attending physician to care for myself or I am duly authorized by the patient as his /her general agent to give consent of such treatment. I hereby give consent for release of medical information to consulting physicians and other medical personnel, as may be required in the rendering of treatment. In the event of collection action, I shall be responsible for any legal fees incurred.

**I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO THE ABOVE NAMED OFFICE FOR THE SERVICESRENDERED.**

PATIENT / RESPONSIBLE PARTY SIGNITURE DATE

**======================================================================================================**

## ASSIGNMENT

I hereby authorize payment directly to the attending physician of any medical / surgical benefits payable to me under the conditions of my policy

for services rendered. I hereby give consent for release to authorized person of financial and medical information concerning care, treatment and

charges as may be required to complete all claims for benefits.

PATIENT / RESPONSIBLE PARTY SIGNITURE DATE