**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