2021 PATIENT REGISTRATION-*Please PRINT legibly*

Patient Name:____ **DOB:**____/____/__________

First Name Last Name

Mother's Name:____ **DOB:**____/____/__________

First Name Last Name

Mother's Phone#:(________**)**________**-**__________ **O Preferred Phone #** **O Alternate Phone #**

(ONLY ONE PARENT MAY HAVE THE PREFERRED PHONE NUMBER)

Father's Name:____ **DOB:**____/____/__________

First Name Last Name

Father's Phone#:(________**)**________**-**__________ **O Preferred Phone #** **O Alternate Phone #**

Address:____

City:_____________________________ **State:**_______________ **Zip:**_________________

Email Address:___________________________________@_____________________________

Responsible Party:____ **O Mother** **O Father**

First Name Last Name

The responsible party may not necessarily be the parent who holds the insurance. It is the parent with whom the child resides with or the parent that receives the confirmation texts, emails &/or voicemails.

Primary Insurance Name:____

Primary Insurance Policy Holder Name:_________________________________ **DOB:**____/____/_________

ID#:_____________________________________

Secondary Insurance Name: ____

Primary Insurance Policy Holder Name:_________________________________ **DOB:**____/____/_________

ID#:_____________________________________

OFFICE USE:

__ID Scanned __Ins Card(s) Scanned __Patient information Verified __Responsible Party Verified

Date:____/____/_________

Name:_________________