



REGISTRATION INFORMATION: New: _____ Change: _____ Date: _____

Name: _____ Phone _____

Age _____ DOB: _____ Sex _____ SSN: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Who is the legal guardian for the Patient? _____

Who is the legally Responsible for the Patient's fees? _____

RESPONSIBLE PARTY (POLICY HOLDER)

Name: _____ Phone _____

Relationship to Patient _____ Legal Guardian: Yes _____ No _____

Home Address: _____ City: _____ State: _____ Zip: _____

Phone _____ DOB: _____ SSN: _____

Drivers License # _____ Employer _____

Occupation _____ Work Phone# _____

PRIMARY INSURANCE INFORMATION

Insurance Name: _____ ID#: _____

Primary Address: _____ City: _____ State: _____ Zip: _____

SECONDARY INSURANCE INFORMATION

Insurance Name: _____ ID#: _____

Secondary Address: _____ City: _____ State: _____ Zip: _____

PARENT NAME (NOT POLICY HOLDER)

Parent's SS# _____ Drivers Licence# _____

DOB: _____ Occupation _____

Employer _____ Work # _____

EMERGENCY CONTACT

EMERGENCY PHONE #

I authorize treatment for my child if brought in by someone else in such case that I am unable to bring my child in personally.

I hereby consent to and authorize the administration of all treatments that may be considered advisable and necessary.

I hereby authorize the physician to release any information acquired in the course of my child's examination and treatment.

I understand that I am financially responsible for all expenses incurred regardless of Insurance coverage.

Authorization to pay physician: I hereby authorize payment directly to the physician of benefits otherwise payable to the physician of benefits otherwise payable to me for his service.

Signature: _____ Date: _____

Relationship to Patient _____

How did you hear about our office? _____

Do you require an interpreter? _____