Patient Registration 2020

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Patient Name: _____ Relationship to Guarantor: _____
Date of Birth: _____ Sex: Male ___ Female ___
Home Address: _____
City: _____ State: _____ Zip Code: _____

Preferred Phone #: _____ Circle: Home Cell Work
Preferred Phone # FOR TEXT REMINDERS: _____
E-Mail Address: _____ Preferred Pharmacy #: _____
Referred by: _____

Siblings: **Name** **Sex** **Date of Birth**
_____
_____
_____

Father's/Mother's Name: _____Date of Birth: _____
Home Address (if different): _____
Cell Phone: ( ) _____ Work Phone: ( ) _____
Employer: _____
Occupation: _____ Email: _____
Marital Status: _____

Mother's/Father's Name: _____Date of Birth: _____
Home Address (if different): _____
Cell Phone: ( ) _____ Work Phone: ( ) _____
Employer: _____
Occupation: _____ Email: _____
Marital Status: _____

In the event of any emergency* and in your absence, who, other than the parents, has your permission to bring the child to care and may be contacted regarding your child:

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Parent Signature*: _____ **Witness Signature**: _____
Date: _____ Date: _____
*This allows me to give my verbal permission to add additional emergency contacts to the above list as needed

Office Use Only:
Received: ____ Copy of Driver's License ____ Copy of Insurance Card
Accepted by: ____ C.L. ____ C.Z. ____ E.T. ____ P.N. ____ L.I. ____ T.R. ___ A.C.