Patient Registration Form

Patient's Name: _____ Date of Birth _____ Gender _____
Sibling 1 Name: _____ Date of Birth _____ Gender _____
Sibling 2 Name: _____ Date of Birth _____ Gender _____
Sibling 3 Name: _____ Date of Birth _____ Gender _____
Home address: _____ State: _____ ZIP: _____
Home Phone: _____ Patient's Provider: _____
Race: *White* *Asian* *Hispanic* *African American* *Native American* *Pacific Islander* *Other* *Declined*
Ethnicity: *Hispanic or Latin American* *Non-Hispanic or Latin American* *Decline*
Primary Language: _____ Translator required: *Yes* *No*

Mother: _____
Cell: _____
Email: _____
Date of Birth: _____
Address: ☐ same as above _____
City: _____
State: _____ ZIP: _____
Occupation: _____
Work phone: _____

Father: _____
Cell: _____
Email: _____
Date of Birth: _____
Address: ☐ same as above _____
City: _____
State: _____ ZIP: _____
Occupation: _____
Work phone: _____

Who is the Guarantor (*financially responsible*) for patient's account?
Name: _____ Relationship: _____
Date of Birth: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____

Insurance information (***Please fill out completely***)
Insurance Company and plan type: _____
Address: _____
Subscriber name: _____ Relationship: _____
Subscriber DOB: _____
ID #: _____ Suffix: _____
Group #: _____

Preferred Pharmacy (name, street, town): _____

MyChart
Parent name: _____
Parent DOB: _____
Email: _____
ZIP: _____
Child's email (13 yrs and up) _____

Signature: _____ Date: _____

Print: _____