2023 PATIENT REGISTRATION

Appt:____/____/2023 @ ___:_____am/pm

w/Dr._______

-Please PRINT legibly

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

First Name Last Name

Patient resides with:

___Mother & Father(MARRIED) ___PARENTS DIVORCED(SHARED CUSTODY) ___Mother ONLY ___Father ONLY

___Mother & Step-Father ___Father & Step-Mother ___Other:___________________________

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)

Mother's Address:___________________________________ **City:**_______________ **State:**_____ Zip:_________

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

First Name Last Name

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

Father's Address:___________________________________ **City:**_______________ **State:**_____ Zip:_________

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.

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

First Name Last Name

Email Address:_______________________________@_________________________ for Mother/Father

(ONLY ONE PARENT MAY HAVE THE PREFERRED EMAIL)

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: _____________________________________

Secondary Insurance Policy Holder Name:______________________________ **DOB:**____/____/_________

ID#:_________________________________

OFFICE USE: **Name:** _______________________ **Date:**__________________

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