CHILD FORM

PLEASE PRINT

PATIENT REGISTRATION

OFFICE USE ONLY

DATE UPDATED _____

_____

_____

REFERRED BY _____ DATE _____

NAME OF PATIENT _____
LAST FIRST MIDDLE NICKNAME

ADDRESS _____
STREET APT. # CITY STATE ZIP CODE

PHONE _____ AGE _____ DATE OF BIRTH _____ SEX _____

FATHER'S NAME _____
LAST FIRST MIDDLE WHERE EMPLOYED WORK PHONE #

HOME ADDRESS _____
STREET APT. # CITY STATE ZIP PHONE

S.S. No. _____ FATHER S.S. No. _____ MOTHER

MOTHER'S NAME _____
LAST FIRST MIDDLE WHERE EMPLOYED WORK PHONE #

HOME ADDRESS _____
STREET APT. # CITY STATE ZIP PHONE

HAVE ANY OF YOUR CHILDREN BEEN SEEN IN THIS OFFICE? ☐ YES ☐ NO

LIST THEIR NAMES _____

NAME OF FRIEND OR NEIGHBOR WHO CAN REACH YOU IN CASE OF EMERGENCY _____

ADDRESS _____ PHONE _____
STREET APT. # CITY STATE ZIP

METHOD OF PAYMENT: ☐ CASH ☐ CHECK ☐ CREDIT CARD (MASTER CARD, VISA)

IS PATIENT COVERED BY INSURANCE? IF SO _____
NAME OF INSURANCE COMPANY POLICY OR I.D. #

_____
SUBSCRIBER NAME

The policy in our office, is the parent who requests treatment for the child is responsible for all fees for services rendered.

_____ _____
Signature Of Parent Requesting Care Date