Patient Registration Form

Today's Date: _____

PATIENT INFORMATION

Name: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Home Address: _____

City: _____ State: _____ Zip: _____

Sibling Names and Ages *(ex: Jack, 9)*: _____

_____

PARENT/GUARDIAN INFORMATION

PRIMARY FAMILY EMAIL: _____

PRIMARY FAMILY PHONE: (____) _____ (*OFFICE USE: LABEL AS "MAIN"*)

Parent Name: _____ Date of Birth: _____

Mobile Phone: (____) _____ **Work Phone:** (___) _____

Home Address (*if different from child*): _____

City: _____ State: _____ Zip: _____

Employer: _____

Parent Name: _____ Date of Birth: _____

Mobile Phone: (____) _____ **Work Phone:** (___) _____

Home Address (*if different from child*): _____

City: _____ State: _____ Zip: _____

Employer: _____

Alternate Contact (relative or friend): _____

Alternate Contact Phone: (____) _____

Relationship to patient: _____

Your Child's Race/Ethnicity
(select one primary)

- ☐ American Indian
- ☐ Asian
- ☐ Black/African American
- ☐ Caucasian
- ☐ Hispanic
- ☐ Multiracial
- ☐ Unknown
- ☐ Other _____
- ☐ Decline to answer

FORM COMPLETED BY:

_____ _____ _____

Name *(print)* **Signature** **Date**