PRIMARY CARE PARTNERS

Account No.	Entered Date
Reg. By	Office Site
☐ New ☐ Change	Info. Change:

Child/Dependent Registration Form

Today's Date: _____

Please complete this form and **sign page 3** in order to ensure proper billing of your services. **Please print.**

Patient Information

Patient Last Name: _____ Social Security Number: _____

First Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Other Name/AKA: _____ Home Phone: (_____) _____

Addr1: _____ Alt Phone: (_____) _____

Addr2: _____ Cell Phone: (_____) _____

City, State, Zip: _____ Email Address: _____

Preferred Method of Contact:
☐ Alt Phone Number ☐ Email ☐ Letter
☐ Phone Call (Cell) ☐ Phone Call (Home)

Ethnicity: **(Data is used for statistical reporting.)**
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Other
☐ Patient Declined

Employment Status:
☐ Employed Full Time ☐ Employed Part Time
☐ Student

Race: **(Data is used for statistical reporting.)**
☐ American Indian ☐ Asian ☐ African American ☐ White ☐ Other
☐ Native Hawaiian/Pacific Islander ☐ Undetermined ☐ Patient Declined

Employer: _____ Language: ☐ English ☐ Spanish ☐ Other _____

Insurance Information (A separate form is required for worker's compensation, automobile liability, or legal services.)

PRIMARY CARRIER: _____ Telephone #: (_____) _____

Address: _____ Child's ID: _____

Subscriber's Name: _____ Group/Plan#: _____ Effective Date: _____

Subscriber's DOB: _____ Sex: ☐ M ☐ F Subscriber SS#: _____

Patient Relationship to Insured: _____ PCP listed on Card: _____

SECONDARY CARRIER: _____ Telephone #: (_____) _____

Address: _____ Child's ID: _____

Subscriber's Name: _____ Group/Plan#: _____ Effective Date: _____

Subscriber's DOB: _____ Sex: ☐ M ☐ F Subscriber SS#: _____

Patient Relationship to Insured: _____ PCP listed on Card: _____

Primary Care Phys: _____ Refer. Phys (if different): _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Telephone #: (_____) _____ Telephone #: (_____) _____

Pharmacy Name, Address & Phone #: _____

Guarantor Information (Guarantor is the person financially responsible for this patient's bill.)

Guarantor: _____ Patient's Relationship to Guarantor: _____

Addr1: _____ Social Security Number: _____

Addr2: _____ Date of Birth: _____ Sex: ☐ M ☐ F

City, State, Zip: _____ Home Phone: (_____) _____

Employer: _____ Work Phone: (_____) _____

Address: _____ Cell Phone: (_____) _____

City, State, Zip: _____ Email Address: _____

Driver's License #: _____ State _____

Other Parent or Guardian

Parent/Guardian: _____ Patient's Relationship to Guardian: _____

Addr1: _____ Social Security Number: _____

Addr2: _____ Date of Birth: _____ Sex: ☐ M ☐ F

City, State, Zip: _____ Home Phone: (_____) _____

Employer: _____ Cell Phone: (_____) _____

Address: _____ City, State, Zip: _____

Work Phone: (_____) _____ Driver's License #: _____ State _____

Emergency Contact Information (Someone living outside the primary household)

Last Name, First Name: _____ Patient's Relationship to Contact: _____

Addr1: _____ Home Phone: (_____) _____

Addr2: _____ Work Phone: (_____) _____

City, State, Zip: _____ Cell Phone: (_____) _____

List All Children/Siblings

Child #1 Last Name	First Name	Date of Birth
Child #2 Last Name	First Name	Date of Birth
Child #3 Last Name	First Name	Date of Birth
Child #4 Last Name	First Name	Date of Birth

How did you hear about our practice?

☐ Billboard ☐ Brochure ☐ Health Fair ☐ Health Plan ☐ Internet ☐ Mass Mailing ☐ Newspaper/Magazine
☐ Ongoing Care ☐ Patient ☐ Phone Book ☐ Phys. Off/ER ☐ Relative ☐ Radio ☐ TV ☐ Word of Mouth ☐ Other