

# 2023 PATIENT REGISTRATION

Appt: \_\_\_/\_\_\_/2023 @ \_\_\_:\_\_\_am/pm

w/Dr. \_\_\_\_\_

-Please **PRINT** legibly

**LEGAL Patient Name:** \_\_\_\_\_  
First Name Last Name

**DOB:** \_\_\_/\_\_\_/\_\_\_\_\_

Patient resides with:

\_\_\_ Mother & Father(MARRIED) \_\_\_ PARENTS DIVORCED(SHARED CUSTODY) \_\_\_ Mother ONLY \_\_\_ Father ONLY

\_\_\_ Mother & Step-Father \_\_\_ Father & Step-Mother \_\_\_ Other: \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_  
First Name Last Name

**DOB:** \_\_\_/\_\_\_/\_\_\_\_\_

**Mother's Phone#:**(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  Preferred Phone #  Alternate Phone #

**(ONLY ONE PARENT MAY HAVE THE PREFERRED PHONE NUMBER)**

**Mother's Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Father's Name:** \_\_\_\_\_  
First Name Last Name

**DOB:** \_\_\_/\_\_\_/\_\_\_\_\_

**Father's Phone#:**(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  Preferred Phone #  Alternate Phone #

**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:** \_\_\_\_\_  
First Name Last Name

Mother  Father

**Email Address:** \_\_\_\_\_ @ \_\_\_\_\_

**(ONLY ONE PARENT MAY HAVE THE PREFERRED EMAIL)**

**SIBLINGS: Patient Name:** \_\_\_\_\_  
First Name Last Name

**DOB:** \_\_\_/\_\_\_/\_\_\_\_\_

**Patient Name:** \_\_\_\_\_  
First Name Last Name

**DOB:** \_\_\_/\_\_\_/\_\_\_\_\_

**Patient Name:** \_\_\_\_\_  
First Name Last Name

**DOB:** \_\_\_/\_\_\_/\_\_\_\_\_

**Patient Name:** \_\_\_\_\_  
First Name Last Name

**DOB:** \_\_\_/\_\_\_/\_\_\_\_\_

**Patient Name:** \_\_\_\_\_  
First Name Last Name

**DOB:** \_\_\_/\_\_\_/\_\_\_\_\_

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:** \_\_\_\_\_ **Policy Holder Name:** \_\_\_\_\_ **DOB:** \_\_\_/\_\_\_/\_\_\_\_\_ **ID#:** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ **Policy Holder Name:** \_\_\_\_\_ **DOB:** \_\_\_/\_\_\_/\_\_\_\_\_ **ID#:** \_\_\_\_\_

**OFFICE USE:** Name: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_ ID Scanned \_\_\_ Ins Card(s) Scanned \_\_\_ Patient information Verified \_\_\_ Responsible Party Verified