

Minor Patient Registration Form

First Middle Last Social Security Number

Date of Birth: _____ Male Female Marital Status: _____

Legal Guardian or Parent Name: _____

Address: _____

Street

City

State

Zip

Preferred Phone: () _____ home work mobile

Alternate Phone: () _____ home work mobile

Pharmacy: _____ () _____

Preferred Language: _____ Ethnicity: Hispanic/Latino Non Hispanic/Latino

Race: American Indian Asian Black/African American White Native Hawaiian/Pacific Islander Other

- **I DO CONSENT TO LEAVE A DETAILED MESSAGE AND/OR DISCUSSION:** I give Cynthia Rogers, M.D., P.A. and their staff permission to leave messages on, or to discuss my medical care and/or billing account with, the following:

Person Relationship Number

Person Relationship Number

- **I DO NOT CONSENT TO LEAVE DETAILED MESSAGE:** I would like to be contacted personally, I do not authorize Cynthia Rogers, M.D., P.A. or any of its employees to leave messages or have discussions regarding my medical care and/or billing account with anyone other than myself.

Emergency Contact Information:

In case of Emergency, whom should we notify? _____

Relationship to Patient: _____ Phone#: () _____

Insurance Information: Do you have health insurance? Yes No

Primary Insurance Carrier: _____

Name of Insured (Guarantor): _____ Guarantor Date of Birth: _____

Secondary Insurance Carrier: _____

Name of Insured (Guarantor): _____ Guarantor Date of Birth: _____

Please give your insurance card(s) and your photo identification to the receptionist. The receptionist will make a copy and return them to you promptly.

Patient Signature: _____

Date: _____