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

Home Phone: ( ) ___________________ Mobile Phone: ( )____________________

Preferred Contact Method: Home / Mobile Email Address: ______________________________

Primary Care Physician: ________________________ Referring Provider: ________________________

Pharmacy: ______________________________ Pharmacy Location: ___________________________

Preferred Language: __________________

ETHNICITY: Hispanic/Latino Non-Hispanic/Latino Prefer Not to Answer

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

I DO / DO NOT consent to the office leaving a detailed message containing medical information at any of the phone numbers listed above. (*CIRCLE ONE*)

I DO / DO NOT consent to the office discussing my medical information with: (*CIRCLE ONE*)

Person: __________________________________Relationship to patient: _______________

Person: __________________________________Relationship to patient: _______________

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:___________________

Patient Signature:_________________________________ **Date:**________________