NORTHWESTERN CHILDREN'S PRACTICE

PATIENT REGISTRATION FORM

Patient Information

First Name (Legal):_____ Last Name:_____

Birthdate: _____ Sex: Male:_____ Female: _____ Preferred Language:_____

Parent/Guardian Information

Parent #1 First Name:_____Last Name:_____

Date of Birth_____Social Security #_____Sex:_____

Primary Number:_____Alternate Number:_____

Address:_____City/State_____Zip Code_____

Employer:_____ Occupation:_____

Email:_____ Would you like to be added to our newsletter? _____

Emergency Contact:_____Emergency Phone:_____

Parent #2 First Name:_____Last Name:_____

Date of Birth_____Social Security #_____Sex:_____

Primary Number:_____Alternate Number:_____

Address:_____City/State_____Zip Code_____

Employer:_____ Occupation:_____

Email:_____ Would you like to be added to our newsletter? _____

Demographic Information

Race: _____American Indian _____Asian _____African American _____Hispanic
_____White or Caucasian _____Other Race _____Prefer not to Answer

Ethnicity: _____Hispanic or Latino _____Not Hispanic _____Prefer not to Answer

Insurance Information

Primary Insurance Carrier:_____
Policy ID #_____ Group #_____
Policy Holder Name:_____Policy Holder SS Number:_____

Preferred Pharmacy

Name:_____Address:_____City:_____

I authorize treatment of my child. I authorize the release of pertinent medical information to insurance carriers. I authorize my insurance company to pay directly to the doctor.

Signature:_____**Date:**_____
Parent/Legal Guardian