PATIENT REGISTRATION FORM

Please **PRINT LEGIBLY** and **COMPLETE ALL information** on this form.

Please list all children;

Last	First	D.O.B.	Resides With

MOTHER'S NAME: _____ _____ _____ _____
Last First Middle D.O.B.
Address: _____
Employer: _____Occupation:_____
Cell Phone No: _____Home Phone No:_____
What is your preference on how to receive reminder call's:_____
e-mail address:_____ This e-mail address will be used to grant access to the patient portal.
For safety compliance Each Parent must use their own individual e-mail address for access.

FATHER'S NAME: _____ _____ _____ _____
Last First Middle D.O.B.
Address: _____
Employer: _____Occupation:_____
Cell Phone No: _____Home Phone No:_____
e-mail address:_____ This e-mail address will be used to grant access to the patient portal.
For safety compliance Each Parent must use their own individual e-mail address for access.

PLEASE LIST ALL INDIVIDUALS THAT HAVE YOUR CONSENT TO BE INVOLVED WITH YOUR CHILD'S / Your CHILDREN'S HEALTH CARE & MIGHT ACCOMPANY THEM IN TO OUR OFFICE.

PLEASE NOTE - if an individual's name does not appear on this list and presents your child to this office for treatment they will be asked to reschedule the appointment at which time they can provide us with your authorization for treatment.

Names and Relationship to the child:

1._____ 2._____
3._____ 4._____
5._____ 6._____
7._____ 8._____
9._____ 10._____

Signature of responsible party: _____Relationship:_____

Date: _____