Patient Registration

Please complete the patient(s)' demographic information. **ALL ITEMS MUST BE COMPLETED.**

Patient Information	
Last Name:	First Name:
Middle Name:	Date of Birth:
Preferred Name:	Gender at Birth:
Preferred Gender:	Patient's Cell Number:
Preferred Language:	Order at Birth:
Race:	Ethnicity:

Parent/Guardian Information		
Parent Legal Guardian's Name (Main Contact):	Date of Birth:	Phone Number:
Mailing Address:	City, State, Zip:	Employer:
Physical Address if different:	City, State, Zip:	Email (for portal access):
Parent Legal Guardian's Name (Secondary Contact):	Date of Birth:	Phone Number:
Mailing Address (if different from primary contact):	City, State, Zip:	Employer:
Physical Address (if different from primary contact):	City, State, Zip:	Email (for portal access):

Who is the primary caregiver for the patient?		If applicable, who has custody of the patient? (please provide proper court documentation)
Emergency Contact (Name, Phone Number, Relationship to the patient):		How would you like to receive reminders and notifications? (*Circle one or more) Call Text Email
Sibling Information (list only if established or future patients)		
Patient First Name, Last Name, Date of Birth:		Patient First Name, Last Name, Date of Birth:
Patient First Name, Last Name, Date of Birth:		Patient First Name, Last Name, Date of Birth:
Insurance Information (please provide card at each visit)		
Primary Insurance Carrier:	Member ID/Group Number:	Policy Holder's Name:
No Insurance/Self Pay, please list details below:		