Patient Registration

Full Name of Each Child | Nickname | Age | Birthdate

1.______________________________ ____________________ ____ ____________

2.______________________________ ____________________ ____ ____________

3.______________________________ ____________________ ____ ____________

4.______________________________ ____________________ ____ ____________

Insurance Information

Insurance Plan Name ________________________________Group#____________________

Subscriber Name or ID# ____________________________ Birthdate___________________

Address ____ Phone# ____________________

Parent Information

Children live with: both parents mother father other ____________________________________

Parent's Name ___________________________ Parent's Name_____________________________

Address ________________________________ Address ________________________________

Cell # ______________ Home# _____________ Cell #________________ Home#______________

Birthdate__________Social Security #___________ Birthdate__________ Social Security#______________

Driver's License# ________________ State _____ Driver's License# __________________ State _____

Employer_________________________________ Employer _________________________________

Work Address ____________________________ Work Address ______________________________

Work phone# _____________________________ Work Phone# ______________________________

Emergency Contact (other than parent)

Name __________________________ Relationship_______________ Phone#____________
Name__________________________ Relationship_______________ Phone#____________

Privacy Constraints

How may we contact you with personal medical information?

No Restrictions. It is ok to leave messages with information the following number(s):
____

Restricted. Only non-specific messages
Please note any other privacy restrictions_______________________________________

Authorization: I hereby authorize Dr. Kristin Andrade to furnish information to insurance carriers concerning medical care, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am responsible for providing accurate and current insurance and contact information at the time of service. I understand that I am financially responsible for all charges whether or not covered by insurance.

Signature:____ Date:______________
Printed Name:_________________________________ Relationship to patient:______________