CHILD HEALTH PARTNERS
Patient Registration

TODAYS DATE _____

Child 1: *Last Name:* _____ *First Name:*_____ *MI:*_____

D.O.B.: __ /____ / ____ *Sex:*_____ *Primary Language:* _____

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race:* Asian / Black / Hawaiian / White

Child 2: *Last Name:* _____ *First Name:*_____ *MI:*_____

D.O.B.: __ /____ / ____ *Sex:*_____ *Primary Language:* _____

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race:* Asian / Black / Hawaiian / White

Child 3: *Last Name:* _____ *First Name:*_____ *MI:*_____

D.O.B.: __ /____ / ____ *Sex:*_____ *Primary Language:* _____

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race:* Asian / Black / Hawaiian / White

Mailing Address:

_____

(Street or PO Box) *(City)* *(State& Zip)*

Home Phone: (____) _____-_____

Who lives at this household? _____

Insurance:

Primary Policy: *Policy Holder's Name*:_____

Policy Holder's Birth Date: _____ *Policy Holder's Sex:* Male / Female

Insurance Carrier: _____ *Social Security #:* ____ - ___ - ___

*ID#*_____ *Group #* _____

Secondary Policy: *Policy Holder's Name*:_____

Policy Holder's Birth Date: _____ *Policy Holder's Sex:* Male / Female

Insurance Carrier: _____ *Social Security #:* ____ - ___ - ___

*ID#*_____ *Group #* _____

OVER

Parent 1: *Name:*_____ *Relation to Patient:*_____

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____

Address _____ *City* _____ *Zip* _____

Work Phone: (____)_____ - _____ *Cell Phone:* (_____)_____ - _____

Home Email: _____ *Work Email:*_____

*Employer:*_____ *Occupation:*_____

Parent 2: *Name:*_____ *Relation to Patient:*_____

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____

Address _____ *City* _____ *Zip* _____

Work Phone: (____)_____ - _____ *Cell Phone:* (_____)_____ - _____

Home Email: _____ *Work Email:*_____

*Employer:*_____ *Occupation:*_____

If parents are divorced or separated please fill out this section:

*Who has custody?*_____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

Emergency Contacts, <u>other than parents:</u> Name & Relationship

1. _____ Phone: (____) _____ - _____

2. _____ Phone: (____) _____ - _____