Patient Registration Form

Patient Information				
First Name:	Middle:	Last:	Suffix:	
DOB:	Sex:			
Mailing Address:		City:	State:	Zip:
Preferred phone number for appointment confirmations:				
Patient lives with:	Who should receive mail regarding balances and appointments?			
Preferred Physician:				

Primary Guarantor Information				
First Name:	Middle:	Last:	Suffix:	
DOB:	Sex:	SSN:	Relationship to Patient:	
Cell Phone:	Home Phone:	Work Phone:		
Mailing Address:		City:	State:	Zip:
Employer:	Occupation:			

Additional Parent or Guardian Information				
First Name:	Middle:	Last:	Suffix:	
DOB:	Sex:	SSN:	Relationship to Patient:	
Cell Phone:	Home Phone:	Work Phone:		
Mailing Address:		City:	State:	Zip:
Employer:	Occupation:			

Primary Insurance			
Insurance Name:	Subscriber ID:	Group ID:	
Subscribers Name:	Date of Birth:	Relationship to Patient:	
If the subscriber is not listed above, please complete the information below.			
Mailing Address:	City:	State:	Zip:
Cell Phone:	Home Phone:	Work Phone:	

Secondary Insurance			
Insurance Name:	Subscriber ID:	Group ID:	
Subscribers Name:	Date of Birth:	Relationship to Patient:	
If the subscriber is not listed above, please complete the information below.			
Mailing Address:	City:	State:	Zip:
Cell Phone:	Home Phone:	Work Phone:	

The Children's Clinic bills your insurance as a courtesy. Payment is expected at the time of the service for co-payments, deductibles, and any services and supplies not covered by insurance / Medicaid. I acknowledge that The Children's Clinic will bill my insurance as a courtesy and that I am responsible for the balance. I authorize The Children's Clinic to release all information necessary to secure the payment of medical benefits and for said benefits be paid directly to The Children's Clinic.

Signature of Parent / Legal Guardian:_____ Date: _____