

SOUTH LAKE PEDIATRICS

PATIENT REGISTRATION

Patient ID# _____

Chart Location _____

PATIENT'S LAST NAME		FIRST NAME		MIDDLE	
PATIENT'S PREFERRED NAME:			PHONE 1:		
ADDRESS			PHONE 2:		
CITY	STATE	ZIP CODE	PHONE 3:		
DATE OF BIRTH		SEX	SCHOOL NAME:		
PATIENT'S SOCIAL SECURITY #		PRIMARY LANGUAGE:		EMAIL ADDRESS:	
SIBLINGS AND BIRTHDATES			PREVIOUS CLINIC OR OB GYN:		
EMERGENCY CONTACT (OTHER THAN PARENT)				RELATIONSHIP	
PHONE #					
ADDRESS		CITY	STATE	ZIP	
MOTHER'S NAME			FATHER'S NAME		
ADDRESS (if different)			ADDRESS (if different)		
HOME PHONE (if different)			HOME PHONE (if different)		
BIRTHDATE		BIRTHDATE			
SSN#		SOCIAL SECURITY #			
OCCUPATION		OCCUPATION			
EMPLOYER		EMPLOYER			
WORK PHONE		CELL PHONE	WORK PHONE		CELL PHONE
PARENT'S MARITAL STATUS (CIRCLE) MARRIED WIDOWED DIVORCED SINGLE LEGALLY SEPARATED OTHER					
PERSON RESPONSIBLE FOR BILL					
PRIMARY INSURANCE NAME			PHONE #		
INSURANCE ADDRESS			EFFECTIVE DATE		
POLICY HOLDER			PATIENT'S RELATIONSHIP TO INSURED		
I.D.#		GROUP #	GROUP NAME		
SECONDARY INSURANCE NAME			PHONE #		
INSURANCE ADDRESS			EFFECTIVE DATE		
POLICY HOLDER			PATIENT'S RELATIONSHIP TO INSURED		
I.D.#		GROUP #	GROUP NAME		
I AGREE THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.			RELATIONSHIP TO ABOVE PATIENT:		
			_____ PRINT NAME (PATIENT OR PARENT IF MINOR)		
			_____ SIGNATURE (PATIENT OR PARENT IF MINOR)		_____ DATE