New Patient Registration

Child's full name: _____

Date of birth: _____ **Sex:** _____

Home address: _____

Child lives with (check all): ☐ Both parents ☐ Mother ☐ Father ☐ Guardian

☐ Other: _____

Parent/Guardian 1 name: _____

Phone: _____ Email: _____

Parent/Guardian 2 name: _____

Phone: _____ Email: _____

Insurance company: _____

Member ID: _____ Group number: _____

Secondary insurance (if any): _____

Preferred pharmacy (name and town):

_____

Emergency contact (name and phone):

_____

How did you hear about us?:

_____