**PATIENT REGISTRATION** □ **NEW** □ **UPDATED** **TODAY'S DATE** _____

| **PATIENT INFORMATION** | | | |
|---|---|---|---|
| NAME LAST FIRST MIDDLE | | | NICKNAME |
| SOCIAL SECURITY # | SEX □ MALE □ FEMALE | | DATE OF BIRTH ____/____/_____ |
| STREET ADDRESS | CITY | STATE | ZIP |
| HOME PHONE # | | | |

| **GENERAL INFORMATION** | |
|---|---|
| **PARENT/GUARDIAN #1- FULL NAME** | **PARENT/GUARDIAN #2- FULL NAME** |
| ADDRESS | ADDRESS |
| CITY STATE ZIP | CITY STATE ZIP |
| HOME PHONE # | HOME PHONE # |
| CELL PHONE # | CELL PHONE # |
| DATE OF BIRTH | DATE OF BIRTH |
| OCCUPATION | OCCUPATION |
| EMPLOYER | EMPLOYER |
| WORK PHONE # | WORK PHONE # |
| EMPLOYER ADDRESS | EMPLOYER ADDRESS |
| E-MAIL ADDRESS | E-MAIL ADDRESS |
| **CHILD LIVES WITH:** | **WHO IS RESPONSIBLE FOR YOUR CHILD'S ACCOUNT?** |
| NAME(S) AND AGE(S) OF BROTHERS & SISTERS | |

| **INSURANCE INFORMATION**<br>*PROOF OF INSURANCE IS REQUIRED BY PROVIDING INSURANCE CARD AT EACH TIME OF SERVICE* | | | |
|---|---|---|---|
| **PRIMARY INSURANCE COMPANY NAME** | | **SECONDARY INSURANCE COMPANY NAME** | |
| POLICY HOLDER'S NAME | | POLICY HOLDER'S NAME | |
| DATE OF BIRTH | SOCIAL SECURITY # | DATE OF BIRTH | SOCIAL SECURITY # |
| RELATIONSHIP TO PATIENT | | RELATIONSHIP TO PATIENT | |

| **EMERGENCY CONTACT INFORMATION** | | |
|---|---|---|
| NAME | | RELATIONSHIP TO PATIENT |
| HOME PHONE # | WORK PHONE # | CELL PHONE # |

I understand that I am financially responsible for all charges whether or not they are paid by my insurance or employer. I authorize said assignee to release all information necessary to secure the payment. I assign surgical benefits, major medical or Medicare to Kids Health Partners, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is as valid as an original.

**PATIENT OR LEGAL GUARDIAN SIGNATURE** _____ **DATE** ____/_____/_____