PATIENT REGISTRATION ☐ NEW ☐ UPDATED TODAY'S DATE: _____

NAME: LAST	FIRST	MIDDLE	NICKNAME
SEX: ☐ MALE ☐ FEMALE		DATE OF BIRTH: _____ / _____ / _____	
STREET ADDRESS		CITY	STATE / ZIP
HOME PHONE #			

GENERAL INFORMATION

PARENT/ GUARDIAN #1- FULL NAME	SEX:	PARENT/ GUARDIAN #2- FULL NAME	SEX:
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

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 _____ / _____ / _____	DATE OF BIRTH _____ / _____ / _____
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.

PARENT OR LEGAL GUARDIAN SIGNATURE: _____ DATE: _____