



PATIENT ENROLLMENT INFORMATION

NAME (Last, First, Middle Initial)		BIRTHDATE	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
MAILING ADDRESS		CITY, STATE, ZIP	
PRIMARY PHONE (TEXT Y N)	ALTERNATE PHONE	MAY WE LEAVE A MESSAGE <input type="checkbox"/> Yes <input type="checkbox"/> No	PRIMARY LANGUAGE

PARENT/GUARANTOR INFORMATION

NAME (Last, First, Middle Initial)		SSN#	BIRTHDATE	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
MAILING ADDRESS (if different from patient)		CITY, STATE, ZIP		LIVES W/PT <input type="checkbox"/> YES <input type="checkbox"/> NO
PRIMARY PHONE (TEXT Y N)	ALTERNATE PHONE	EMAIL ADDRESS (used for secure patient portal access)		
EMPLOYER		WORK PHONE NUMBER	RELATIONSHIP TO PATIENT <input type="checkbox"/> PARENT <input type="checkbox"/> STEP-PARENT <input type="checkbox"/> GUARDIAN	

OTHER PARENT INFORMATION

NAME (Last, First, Middle Initial)		SSN#	BIRTHDATE	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
MAILING ADDRESS (if different from patient)		CITY, STATE, ZIP		LIVES W/PT <input type="checkbox"/> YES <input type="checkbox"/> NO
PRIMARY PHONE (TEXT Y N)	ALTERNATE PHONE	EMAIL ADDRESS (only if different from guarantor)		
EMPLOYER		WORK PHONE NUMBER	RELATIONSHIP TO PATIENT <input type="checkbox"/> PARENT <input type="checkbox"/> STEP-PARENT <input type="checkbox"/> GUARDIAN	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY ID NUMBER	GROUP NUMBER
NAME OF OWNER OF POLICY		RELATIONSHIP OF OWNER OF POLICY TO PATIENT	
OWNER OF POLICY DATE OF BIRTH	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	OWNER OF POLICY EMPLOYER	
COPAY AMOUNT	DEDUCTIBLE AMOUNT		

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY ID NUMBER	GROUP NUMBER
NAME OF OWNER OF POLICY		RELATIONSHIP OF OWNER OF POLICY TO PATIENT	
OWNER OF POLICY DATE OF BIRTH	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	OWNER OF POLICY EMPLOYER	
COPAY AMOUNT	DEDUCTIBLE AMOUNT		

AUTHORIZED INDIVIDUALS TO ACCOMPANY CHILD FOR MEDICAL CARE – Please list anyone who may ever need to bring your child in, in the event that you cannot. In the event of an emergency, only people you authorize and are listed on your child’s chart, per HIPAA requirements, will be able to accompany your child for treatment without you being present. This does not allow for access to medical records. Your signature below acknowledges your approval of these individuals.

NAME (Last, First, Middle Initial)	RELATIONSHIP	Date of Birth	PRIMARY PHONE
NAME (Last, First, Middle Initial)	RELATIONSHIP	Date of Birth	PRIMARY PHONE
NAME (Last, First, Middle Initial)	RELATIONSHIP	Date of Birth	PRIMARY PHONE
NAME (Last, First, Middle Initial)	RELATIONSHIP	Date of Birth	PRIMARY PHONE
NAME (Last, First, Middle Initial)	RELATIONSHIP	Date of Birth	PRIMARY PHONE

PHARMACY INFORMATION

NAME OF PHARMACY

ADDRESS

OTHER INFORMATION

RACE:
 Asian Black or African American
 White Native Hawaiian or Other Pacific Islander
 Hispanic Other Race Choose not to report

ETHNICITY:
 Hispanic or Latin Not Hispanic or Latin
 Choose not to report

HOW MAY WE CONTACT YOU FOR APPOINTMENT CONFIRMATIONS, LAB RESULTS, AND PATIENT COMMUNICATION? (Choose all that apply)

Phone Call / Voice Message
 Text Message

Confirmations are made as a courtesy. You are still responsible for keeping all scheduled appointments or cancelling 24 hrs prior. Thank you.

I hereby agree that this information is correct and I understand that I must provide in writing any changes to the above information. I understand that supplying my insurance information does not guarantee payment by my insurance and that I am responsible for payment of any charges not covered by my insurance.

Patient Name (Please print)

Signature of Parent or Guardian

Printed Name of Parent or Guardian

Date