

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 #			Email Address			
Primary Language		Race	Country of Origin			
Siblings and Birthdates			Previous Clinic or OB Gyn			
Emergency Contact (other than parent)			Relationship			
Phone #						
Address		City	State	Zip Code		
Mother's Name			Father's Name			
Address (if different)			Address (if different)			
Home Phone (if different)			Home Phone (if different)			
Birthdate			Birthdate			
SSN#			SSN#			
Occupation			Occupation			
Employer			Employer			
Work Phone	Cell Phone	Work Phone	Cell Phone			
Parent's Marital Status (circle) Married Widowed Divorced Not Married Legally Separated Partner Other						
Person Responsible for Bill						
Primary Insurance Name			Phone #			
Insurance Address			Effective Date			
Policy Holder			Patient's Relationship to			
I.D. #	Group #		Group Name			
Secondary Insurance Name			Phone #			
Insurance Address			Effective Date			
Policy Holder			Patient's Relationship to			
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	