495 SW Ramsey Ave. • Grants Pass, OR 97527 • (541) 476-6644

PEDIATRIC PATIENT REGISTRATION

PATIENT INFORMATION — Child 1

PATIENT'S FULL NAME Last	First	Initial	Sex M F
Address			DOB
City	State	Zip	Home Phone

PATIENT INFORMATION — Child 2

PATIENT'S FULL NAME Last	First	Initial	Sex M F
Address _____ ✓ if same as Child 1			DOB
City	State	Zip	Home Phone

PATIENT INFORMATION — Child 3

PATIENT'S FULL NAME Last	First	Initial	Sex M F
Address _____ ✓ if same as Child 1			DOB
City	State	Zip	Home Phone

PATIENT INFORMATION — Child 4

PATIENT'S FULL NAME Last	First	Initial	Sex M F
Address _____ ✓ if same as Child 1			DOB
City	State	Zip	Home Phone

Who has legal custody of patient(s): ____ Parent____ Mother Only____ Father Only____ Foster Parent____ Grandparent
*If not biological/natural parents, court documents must be present at time of visit

PARENT- LEGAL GUARDIAN Last Name			First	Initial
Address _____ ✓ if same as patient				DOB
City	State	Zip	Home Phone	Driver's License
Employer	Work Phone	Occupation		

- Continued on Back -

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY Last Name	First	Initial	Relationship to patient
Address _____ ✓ if same as patient			DOB

City	State	Zip	Home Phone	Driver's License

Employer	Work Phone	Occupation

PATIENT EMERGENCY CONTACT

Contact Name	Relationship

Emergency Contact Address	Phone	Alternate Phone

City	State	Zip

INSURANCE INFORMATION

Primary Insurance Carrier	Member ID	Group No.
Subscriber Name:	Subscriber DOB	Group Name:
Secondary Insurance Carrier	Member ID	Group No.
Subscriber Name	Subscriber DOB	Group Name

I CERTIFY THAT THE INFORMATION I HAVE GIVEN IS TRUE AND CORRECT

_______________________________________   ____________________

Signature   *Date*