integrapy
MAKING THE CONNECTION

CHILD PATIENT REGISTRATION FORM

(Please Print Clearly)

Today's Date:			
CLIENT INFORMATION			
Last Name:	**First:**	**Middle:**	❍ Male ❍ Female
Address:			**Apt#:**
City:	**State:**		**Zip:**
Home Phone: ( )	**Social Security no.:**		
Birth date:	**Age:**		**Birth Place:**
School:			**Grade:**
Is student living with both natural parents? ❍ Yes ❍ No If no, please explain: (Adoption, divorce, death, etc.)			
Present Mother:		**Social Security no.:**	
Mother phone no.: ( )		**Mother cell no.:** ( )	
Address (If different from child):			
Are you employed? ❍ Yes ❍ No		**Occupation:**	
Present Father:		**Social Security no.:**	
Father phone no.: ( )		**Father cell no.:** ( )	
Address (If different from child):			
Are you employed? ❍ Yes ❍ No		**Occupation:**	
Who referred you to our office?:			
Who is financially responsible for this bill?			
I will be paying today by: ❍ Cash ❍ Cheque ❍ Credit Card ❍ Debit Card			

integrapy
MAKING THE CONNECTION

INSURANCE INFORMATION	
(Please give your insurance card to the receptionist.)	
Person responsible for bill:	**Birth date:**
Address (if different):	**Home phone no.:** ( )
Is this person a patient here? ❍ Yes ❍ No	
Occupation:	**Employer:**
Employer address:	**Employer phone no.:** ( )
Is this patient covered by insurance? ❍ Yes ❍ No	
Please indicate primary insurance: ❍ Insurance ❍ Welfare (Please provide coupon) ❍ Other	
Subscriber's name:	**Subscriber's S.S. no.:**
Birth date:	**Group no.:**
Policy no.:	**Co-payment:** $
Patient's relationship to subscriber: ❍ Self ❍ Spouse ❍ Child ❍ Other	
Name of secondary insurance (if applicable):	
Subscriber's name:	
Group no.:	**Policy no.:**
Patient's relationship to subscriber: ❍ Self ❍ Spouse ❍ Child ❍ Other	
IN CASE OF EMERGENCY	
Name of local friend or relative (not living at same address):	
Relationship to patient:	
Home phone no.: ( )	**Work phone no.:** ( )
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.	
Patient/Guardian signature	**Date**