REGISTRATION FORM

Do all children have the same Insurance coverage? Yes [ ] No [ ]			PCP: Dr. Tanase		
PATIENT INFORMATION					
Patient's last name:	First:	Middle:	Date of Birth:	Sex: M	F
1.					
2.					
3.					
Preferred phone no.:	Second phone	Third phone	Additional phone		
Mailing address	City :		State:	ZIP Code:	
How did you find out about us? (Please check one box):		[ ]Friend	[ ]Insurance plan	[ ]Hospital	
[ ]Family	[ ]Dr.	[ ]Close to home/work	[ ]Yellow Pages	[ ]Other	

PERSON FILLING THE FORM: Mother [ ] Father [ ] Grandparent [ ] Guardian [ ] Step-parent [ ] other [ ]			
Name:	Birth date:	Address (if different) than above: same	Home phone no
1.			

OTHER PEOPLE CARING FOR THE CHILD Mother [ ] Father [ ] Grandparent [ ] Guardian [ ] Step-parent [ ] Other [ ]			
Name:	Birth date:	Address (if different) than above: same	Home phone no
2.			
3.			

Insurance:	Insurance Name	Policy Holder Name	Social Security Number:	Date of Birth:	Employer
Main:					
Secondary:					

PERSON FINANCIALLY RESPONSIBLE FOR ANY ADDITIONAL MEDICAL CARE COSTS	**1.**	**2.**

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

PHARMACY OF CHOICE:

E-MAIL:
Used exclusively for reminders or updates. Not shared with any third party. Maximum estimated: 5/year