

## PATIENT REGISTRATION

**PATIENT:** The person seeking medical care.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ SS# (if known): \_\_\_\_\_ Sex: M F  
Date of Birth: \_\_\_\_\_ Guardian (if other than parent): \_\_\_\_\_

**GUARANTOR:** The person holding the insurance who is financially responsible for patient.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M F  
Employed: FT PT Retired NA Occupation: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Employer Phone: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**PRIMARY INSURANCE:** The insurance company that will be billed first.

Insurance Company Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Group #: \_\_\_\_\_ ID#: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**SECONDARY INSURANCE:** The insurance company that will be billed second.

Insurance Company Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Group #: \_\_\_\_\_ ID#: \_\_\_\_\_ Effective Date: \_\_\_\_\_

### FAMILY INFORMATION:

Mom's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Mom's Address Same as patient: Y N If no, please fill in below.  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Mom's Employer: \_\_\_\_\_

Dad's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Dad's Address Same as patient: Y N If no, please fill in below.  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Dad's Employer: \_\_\_\_\_

Guardian (if different than parent): \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

### CONSENT TO TREAT:

I, acting as a guardian to the above patient, hereby give my consent for the above patient to receive medical evaluation and treatment by the provider's at Children's Oasis Pediatrics.

Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_