PATIENT REGISTRATION

CHILD'S LEGAL NAME _____
LAST NAME FIRST MIDDLE

Child's Date of Birth: ____ / ____ / _____ Sex: ☐M ☐F
MONTH DAY YEAR

Address: _____

City: _____ State: _____ Zip: _____ Home Phone (_____) _____

CHILD'S PRIMARY CARE DOCTOR OR REFERRING PHYSICIAN: _____

CHILD IN FOSTER CARE? ☐ YES ☐ NO **IF YES PLEASE DO NOT CONTINUE WITH THIS FORM AND CHECK IN WITH FRONT DESK.**

FATHER: _____ DOB: ____ / ____ / _____ SS# _____
Month Day Year

ADDRESS: ☐ SAME AS PATIENT _____

E-mail address: _____ Cell Phone (_____) _____

Employer: _____ Work Phone (_____) _____

Occupation: _____ Employer's Address: _____

MOTHER: _____ DOB: ____ / ____ / ____ SS# _____
Month Day Year

ADDRESS: ☐ SAME AS PATIENT _____

E-mail address: _____ Cell Phone (_____) _____

Employer: _____ Work Phone (_____) _____

Occupation: _____ Employer's Address: _____

EMERGENCY CONTACT (PERSON NOT LIVING AT YOUR ADDRESS):

Name: _____ Phone (____) _____ Relationship: _____

PLEASE LIST OTHER CHILDREN THAT ARE PATIENTS IN OUR PRACTICE:

Last Name	First Name	DOB	Last Name	First Name	DOB

I hereby give permission to Childhood Health Associates of Salem to treat the above named child for routine care and in my absence, to administer to him/her emergency care as deemed necessary by the physician in attendance. **I hereby authorize** Childhood Health Associates of Salem to release medical information necessary to insurance companies and similar organizations in order to process my insurance claims. **I understand** that I am financially responsible for all charges incurred whether those charges are covered by insurance or not. **I authorize** insurance benefits to be paid directly to Childhood Health Associates of Salem.

Signature _____ Date _____
Parent / legal guardian / emancipated minor