941 755-7000 and 941 2097680

PATIENT REGISTRATION

CHILD 1: Last name ________________________First Name:___________________ MI: __________

DOB: ___/___/___ Sex: F / M Language spoken at Home_______________ School ______________

Circle your Ethnicity: Hispanic / Non-Hispanic. Circle Your Race: Asian/Black/Hawaiian/White

CHILD 2: Last name ________________________First Name:___________________ MI: __________

DOB: ___/___/___ Sex: F / M Language spoken at Home_______________ School ______________

Circle your Ethnicity: Hispanic / Non-Hispanic. Circle Your Race: Asian/Black/Hawaiian/White

CHILD 3: Last name ________________________First Name:___________________ MI: __________

DOB: ___/___/___ Sex: F / M Language spoken at Home_______________ School ______________

Circle your Ethnicity: Hispanic / Non-Hispanic. Circle Your Race: Asian/Black/Hawaiian/White

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MAILING ADDRESS:

Street_____________________________________ City _____________ ST ______ ZIP ____________

Phone (home) _______________ Phone (cell) ______________ Emer. Contact # _______________

Who lives at this Household??? ____

INSURANCE:

Policy Holder's Name _____________________________Policy Holder DOB ______/______/_______

Policy Holder sex: Male / Female. Insurance Carrier Name ________________________________

Policy ID # _____________________Group#______________________ Soc. Sec. ______-_____-_____

ADDITIONAL CONTACT QUESTIONS:

Who Should receive Billing Statements?____

May all contacts have access to the Patient's Records Electronically? YES / NO

EMAIL address for Patient Portal: ____

MAIN CONTACT 1: Name __________________________ Relation to Patient ______________________

Lives with Patient? YES/NO. Work Phone (____) ___________. Cell Phone (____) ______________

Employer Name: ____________________________________ Occupation: ___________________

How would you ideally prefer to be contacted regarding the following: (please circle one)

Medical Issues: Home Phone / Work Phone / Cell Phone/ Home Email

Appointment reminders: Home Phone / V. MSSG CELL / TXT Cell Phone/ Home Email

Recall Notices: Home Phone / V. MSSG CELL / TXT Cell Phone/ Home Email

General Practice Notices: Home Phone / Work Phone / Cell Phone/ Home Email

(new coming soon option for access to Patient Portal)

Patient Portal Notification Home Phone / Work Phone / Cell Phone/ Home Email

CONTACT 2: Name __________________________ Relation to Patient _____________________

Lives with Patient? YES/NO. Work Phone (____) ___________. Cell Phone (____) ______________

Employer Name: ____________________________________ Occupation: ___________________

ADDITIONAL QUESTIONS:

If parents are Divorced or Separated please Fill out this section: If not applicable just circle **(N/A)** and proceed to **Emergencies Contacts Section**

Who has the custody?? ____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child of from obtaining information about the child's medical treatment: YES / NO

If YES, please explain and provide a copy of any legal paperwork that support this restriction.

EMERGENCIES CONTACTS: (*Other than parents*). Please indicate Name and Relationship

1 : ___________________________ Relationship______________ Phone (____) _________ - _______

2 : ___________________________ Relationship______________ Phone (____) _________ - _______