CHILD & TEEN Wellness Center

PATIENT REGISTRATION FORM

1. **PATIENT**: _____ DOB: _____ /_____ /_____ ☐F ☐M
(FIRST NAME) (MIDDLE INITIAL) (LAST NAME)

Language: *English Spanish Chinese Hindi French ASL (Sign language)* Other:_____
Ethnicity: *Hispanic Non-Hispanic Unknown* **Race:** *Asian Black Hawaiian White*

2. **PATIENT**: _____ DOB: _____ /_____ /_____ ☐F ☐M
(FIRST NAME) (MIDDLE INITIAL) (LAST NAME)

Language: *English Spanish Chinese Hindi French ASL (Sign language)* Other:_____
Ethnicity: *Hispanic Non-Hispanic Unknown* **Race:** *Asian Black Hawaiian White*

PARENT / LEGAL GUARDIAN CONTACT

☐ PT LIVES WITH	☐ PT LIVES WITH
Parent:_____☐F ☐M (FIRST NAME) (MIDDLE INITIAL) (LAST NAME)	**Parent:**_____☐F ☐M (FIRST NAME) (MIDDLE INITIAL) (LAST NAME)
Relationship: ☐ Mother ☐ Father ☐ Other_____	**Relationship: ☐ Mother ☐ Father ☐ Other_____**
S.S.: _____-_____-_____*Unknown / Refuse*	**S.S.: _____-_____-_____*Unknown / Refuse***
DOB:_____/_____/_____	**DOB:_____/_____/_____**
Address:_____	**Address:_____**
City:_____St: _____ Zip:_____	**City:_____St: _____ Zip:_____**
Lang.: *English Spanish Russian Hindi* **other:_____**	**Lang.:** *English Spanish Russian Hindi* **other:_____**
Home Email: _____	**Home Email: _____**
Employer: _____	**Employer: _____**
Occupation:_____	**Occupation:_____**
Phone:_____Work:_____	**Phone:_____Work:_____**
Cell:_____	**Cell:_____**

PREFERRED CONTACT METHODS (*Circle One)*

Medical Issues: Home Phone Cell Phone (Circle One)
Reminders & Recalls: Email Text message Home Phone Cell Phone (Circle One)
Billing Statements: Email Mail Address (Circle One)
General Notices: Email Text message Mail Address (Circle One)
Patient Portal: Email Text message (Circle One)

INSURANCE POLICY HOLDER / RESPONSIBLE ADULT / GUARANTOR NAME

POLICY HOLDER NAME: _____ DOB: _____
(FIRST NAME) (MIDDLE INITIAL) (LAST NAME)

RELATIONSHIP: ☐Mother ☐ Father ☐Other_____
INS. CARRIER: _____ID #:_____GROUP #:_____

IS THERE A SECONDARY INSURANCE: ☐ YES? ☐ NO?

POLICY HOLDER NAME: _____ DOB: _____
(FIRST NAME) (MIDDLE INITIAL) (LAST NAME)

RELATIONSHIP: ☐Mother ☐ Father ☐Other_____
INS. CARRIER: _____ID #:_____GROUP #:_____

Signature of responsible Parent / Legal Guardian **Date**

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3. **PATIENT**: _____ DOB: _____ /_____ /_____ ☐F ☐M
(FIRST NAME) (MIDDLE INITIAL) (LAST NAME)

Language: *English Spanish Chinese Hindi French ASL (Sign language)* Other:_____

Ethnicity: *Hispanic Non-Hispanic Unknown* **Race:** *Asian Black Hawaiian White*

Preferred Provider: *Dr. Levy Dr. Block Dr. Kushner KeAndra Jones, CRNP Amy LaCava, CRNP*

4. **PATIENT**: _____ DOB: _____ /_____ /_____ ☐F ☐M
(FIRST NAME) (MIDDLE INITIAL) (LAST NAME)

Language: *English Spanish Chinese Hindi French ASL (Sign language)* Other:_____

Ethnicity: *Hispanic Non-Hispanic Unknown* **Race:** *Asian Black Hawaiian White*

Preferred Provider: *Dr. Levy Dr. Block Dr. Kushner KeAndra Jones, CRNP Amy LaCava, CRNP*

5. **PATIENT**: _____ DOB: _____ /_____ /_____ ☐F ☐M
(FIRST NAME) (MIDDLE INITIAL) (LAST NAME)

Language: *English Spanish Chinese Hindi French ASL (Sign language)* Other:_____

Ethnicity: *Hispanic Non-Hispanic Unknown* **Race:** *Asian Black Hawaiian White*

Preferred Provider: *Dr. Levy Dr. Block Dr. Kushner KeAndra Jones, CRNP Amy LaCava, CRNP*

6. **PATIENT**: _____ DOB: _____ /_____ /_____ ☐F ☐M
(FIRST NAME) (MIDDLE INITIAL) (LAST NAME)

Language: *English Spanish Chinese Hindi French ASL (Sign language)* Other:_____

Ethnicity: *Hispanic Non-Hispanic Unknown* **Race:** *Asian Black Hawaiian White*

Preferred Provider: *Dr. Levy Dr. Block Dr. Kushner KeAndra Jones, CRNP Amy LaCava, CRNP*

7. **PATIENT**: _____ DOB: _____ /_____ /_____ ☐F ☐M
(FIRST NAME) (MIDDLE INITIAL) (LAST NAME)

Language: *English Spanish Chinese Hindi French ASL (Sign language)* Other:_____

Ethnicity: *Hispanic Non-Hispanic Unknown* **Race:** *Asian Black Hawaiian White*

Preferred Provider: *Dr. Levy Dr. Block Dr. Kushner KeAndra Jones, CRNP Amy LaCava, CRNP*

8. **PATIENT**: _____ DOB: _____ /_____ /_____ ☐F ☐M
(FIRST NAME) (MIDDLE INITIAL) (LAST NAME)

Language: *English Spanish Chinese Hindi French ASL (Sign language)* Other:_____

Ethnicity: *Hispanic Non-Hispanic Unknown* **Race:** *Asian Black Hawaiian White*

Preferred Provider: *Dr. Levy Dr. Block Dr. Kushner KeAndra Jones, CRNP Amy LaCava, CRNP*

9. **PATIENT**: _____ DOB: _____ /_____ /_____ ☐F ☐M
(FIRST NAME) (MIDDLE INITIAL) (LAST NAME)

Language: *English Spanish Chinese Hindi French ASL (Sign language)* Other:_____

Ethnicity: *Hispanic Non-Hispanic Unknown* **Race:** *Asian Black Hawaiian White*

Preferred Provider: *Dr. Levy Dr. Block Dr. Kushner KeAndra Jones, CRNP Amy LaCava, CRNP*

CHILD & TEEN
Wellness Center

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