PATIENT REGISTRATION FORM

New Horizons Pediatrics
3945 Okemos Rd, Ste A1
Okemos, MI 48864
Phone: 517-295 5000
Fax: 517-507 5424

PATIENT INFORMATION

Patient First Name: _____ Last Name:_____
D.O.B: _____/_____/_____ Sex: M_____ F_____

Mailing Address: _____
(Street or P.O. Box) (City) (State & Zip)
Home phone: (_____) _____ - _____

Father's First Name_____ Last Name:_____
D.O.B: _____/_____/_____ SS#: _____-_____-_____
Primary phone: (_____) _____-_____
Home phone: (_____) _____-_____
Work phone :(_____) _____-_____
Cell phone: (_____) _____-_____
Email:_____
Employer Name:_____

Mother's First Name: _____ Last Name:_____
D.O.B: _____/_____/_____ SS#: _____
Primary phone: (_____) _____-_____ (if different from father)
Home phone: (_____) _____-_____
Work phone: (_____) _____-_____
Cell phone: (_____) _____-_____
Email:_____
Employer Name: _____

Preferred Pharmacy:
Name:_____
Address:_____
Phone number: (_____) _____-_____

Insurance:
Primary Policy: Holder'sName:_____
Holder's DOB: _____ SSN: _____
Primary Insurance: _____ ID:_____
Group #:_____

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Secondary Policy: Holder's Name:_____
Holder's DOB: _____ SSN_____
Secondary Insurance: _____ ID:_____
Group #: _____

Name of Siblings: 1. _____ Date of Birth: _____
2. _____ _____
3. _____ _____

Name of person caring for child (if different from parent)
_____

Custody:
Who has custody of the child – Mom/Dad/Other (If other, please give details)
_____
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No.

If yes please explain and provide s copy of any legal paperwork that support this restriction:_____
_____

Signature of Parent or Guardian: _____

Date: _____