Patient Registration

Child's Name

First: ______________________________MI: _____Last:______________________________ Sex: M / F

Nickname:___________________________________

Social Security #: ___________________________Date of Birth: ___________________

Race: (circle one) Caucasian / African American / American Indian / Asian / Hispanic / Other________________________

Street Address: ____Zip Code______________________

Cell Phones: Mother: _________________________Father: ________________________Home Phone: ________________________

Work Phone/Other Phone:_ ___________________________Email Address: ____

Parents/Legal Guardian

Lives with child?

Mother: ________________________________ Social Security #: __________________Date of Birth: ___________Y or N

Father: _________________________________Social Security#: ___________________Date of Birth: ___________Y or N

Other:____Y or N

Insurance Information

Financially responsible person: ____

Primary Insurance Plan: ____ Policy #: ____________________________

Secondary Insurance Plan: ____ Policy #: ____________________________

Who else has permission to bring this child to Sweetgrass Pediatrics and authorize treatment?

Name: __________________________________Contact Telephone(s): _____________________Relation to Patient: _______________

Name: __________________________________Contact Telephone(s): _____________________Relation to Patient: _______________

Name: __________________________________Contact Telephone(s): _____________________Relation to Patient: _______________

Siblings (that live with patient)

Sibling Name: _______________________________ Social Security #: _______________________Date of Birth:___ ________ Sex M/F

Sibling Name: _______________________________ Social Security #: _______________________Date of Birth: ____________Sex M/F

Sibling Name: _______________________________ Social Security #:_______________________Date of Birth: ____________Sex M/F

I authorize treatment by Sweetgrass Pediatrics, LLC and agree to be responsible for the cost of the services provided by Sweetgrass Pediatrics, LLC.

Signature: ____ Date: _____________