Salei Primary Care Inc

New Patient Registration

Name:_____ Sex: M___ F___DOB:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone: Home:_____ Work: _____ Cell: _____

Email: _____ SS#:_____

Race: White☐ Black/African American☐ Latino☐ Asian☐ Native American☐ Other☐

Mother/Guardian Information

Name:_____ Sex: M☐ F☐DOB:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone: Home:_____ Work: _____ Cell: _____

Email: _____ SS#:_____

Father/Guardian Information

Name:_____ Sex: M☐ F☐DOB:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone: Home:_____ Work: _____ Cell: _____

Email: _____ SS#:_____

Please provide the name and relationship of the person/persons, other than guardians listed above, authorized to accompany your child to the office for sick and well visits.

Name of Person	Relationship to Child	Phone Number	Relationship to child	Authorizing Consent to Treat
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Insurance Information

Primary Insurance:_____ ID number:_____

Policyholders name:_____ DOB:_____ SS#:_____

Address (if different from above):_____

Secondary Insurance:_____ ID number:_____

Policyholders name:_____ DOB:_____ SS#:_____

Address (if different from above):_____

I do hereby agree and give my consent to the physician to furnish medical care and treatment considered necessary and proper in diagnosing or treating my physical and mental condition. I understand my physician may utilize a nurse to assist with my plan of care.

_____ _____

Signature of Patient or Legal Guardian Relationship to Patient

_____ _____

Print Patient's Name Date

_____

Print Name of Patient or Legal Guardian, if applicable