

## Avery Mae Pediatrics Registration Form

Date \_\_\_\_\_ Best Number to Reach You \_\_\_\_\_

Children in Family:

	First	Middle	Last	DOB	Gender	Race	Nickname
1.	_____	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____	_____

Guarantor(Parent Responsible for Payment)

Name \_\_\_\_\_ DOB \_\_\_\_\_ Gender \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_

SSN \_\_\_\_\_ Person Child Lives With \_\_\_\_\_

(SSN necessary in some instances for insurance purposes and referrals)

Please list any person other than parents who are allowed to bring your child or children to the physician and whom you give permission to speak to the physician regarding your child or children's health.

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

How did you hear about us? \_\_\_\_\_