Legacy Family Medicine, P.C
CHILD/ADOLECENT REGISTRATION

PATIENT INFORMATION

PATIENT NAME (Last) (First) (Middle)			☐ Male ☐ Female
ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE ( )	SS# | | |–| | |–| | | |	BIRTH DATE | |–| | |–| | | |	
PRIMARY CARE PHYSICIAN	REFERRED OR RECOMMENDED BY		

PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN ______________ RELATIONSHIP

NAME		
ADDRESS		
CITY	STATE	ZIP
TELEPHONE ( )	BIRTH DATE | |–| | |–| | | |	
SS# | | |–| | |–| | | |		
EMPLOYER	OCCUPATION	
EMPLOYER ADDRESS		
EMPLOYER TELEPHONE ( )	HOW LONG EMPLOYED	

PARENT/GUARDIAN ______________ RELATIONSHIP

NAME		
ADDRESS		
CITY	STATE	ZIP
TELEPHONE ( )	BIRTH DATE | |–| | |–| | | |	
SS# | | |–| | |–| | | |		
EMPLOYER	OCCUPATION	
EMPLOYER ADDRESS		
EMPLOYER TELEPHONE ( )	HOW LONG EMPLOYED	

INSURANCE INFORMATION

PRIMARY INSURANCE		SUBSCRIBER	BIRTH DATE
ADDRESS	CITY	STATE	ZIP CODE
POLICY #	GROUP #	EMPLOYEE ID#/SS#/MISC	GROUP NAME
INSURANCE COMPANY TELEPHONE ( )		PRE-CERTIFICATION TELEPHONE ( )	

SECONDARY INSURANCE		SUBSCRIBER	BIRTH DATE
ADDRESS	CITY	STATE	ZIP CODE
POLICY #	GROUP #	EMPLOYEE ID#/SS#/MISC	GROUP NAME
INSURANCE COMPANY TELEPHONE ( )		PRE-CERTIFICATION TELEPHONE ( )	

OTHER INFORMATION

NEAREST RELATIVE NOT RESIDING AT SAME ADDRESS

NAME		RELATIONSHIP	
ADDRESS	CITY	STATE	ZIP CODE
WORK TELEPHONE ( )		HOME TELEPHONE ( )	
EMERGENCY CONTACT	RELATIONSHIP	TELEPHONE ( )	

PARENT/LEGAL GUARDIAN SIGNATURE	**DATE**

UPDATES

DATE	SIGNATURE	DATE	SIGNATURE
DATE	SIGNATURE	DATE	SIGNATURE

MM-17305B (1/07-GS)

CHILD REGISTRATION