

**Child & Student
 Registration Form**

Please  **in Black Pen**

Office Use: _____

New Update New Problem

Today's Date _____ / _____ / _____

First Name		Middle	Last		Social Security #		Home Phone ()	
School Attending	Age	Date of Birth	Name you would like us to call you (Optional)		<input type="checkbox"/> Female <input type="checkbox"/> Male		Cell Phone ()	
Mailing Address			City	State	Zip		e-mail address:	
Residential Address			City	State	Zip			
If you are working, Employer's Address:					Phone:			
Mother's Full Name			Occupation	Employer & Address			Work Phone	
Father's Full Name			Occupation	Employer & Address			Work Phone	
Person to contact in an Emergency WHO DOES NOT LIVE WITH YOU Name			Relationship	Address			Telephone	
Family Doctor			Address					
We routinely send a copy of your office note to your family physician regarding your care. If we participate with your HMO, we are required to send a letter to your referring physician.								
Are you being seen at the request of a medical provider: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list Name and Address of that provider:								
Why did you choose our practice? <input type="checkbox"/> Employer <input type="checkbox"/> Ins. Co. <input type="checkbox"/> Friend/Relative <input type="checkbox"/> Hospital <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Seminar <input type="checkbox"/> Website <input type="checkbox"/> TV <input type="checkbox"/> Attorney <input type="checkbox"/> Health Fair <input type="checkbox"/> Newspaper <input type="checkbox"/> Other _____ Name of referring person (i.e. Hospital, Attorney, Friend): _____								
Describe in your own words the reason for your visit, in detail.								
Date of Injury or Onset of Problem			Have you been treated for this prior to today			<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, Explain on next line
Where			When		Physician			
Were X-rays taken? <input type="checkbox"/> Yes <input type="checkbox"/> No			Where		When			
Please Complete your Insurance Information:								
What is your annual deductible? _____			How much have you currently met? _____					
A. Insurance Company Name	Address		Policy Owner's Name & Date of Birth		Policy Certificate #		Group #	
1. Primary								
2. Secondary								
3. Tertiary								
IS THIS A WORKERS COMPENSATION INJURY?			DATE OF INJURY					

Parent/Guardian Signature: _____ Date: _____