PATIENT REGISTRATION (under 18)

Patient's Given Name: _____
(First) (Middle) (Last)

Preferred Name: _____

Address: _____
(Apt #) (City) (State) (Zip)

Date of Birth: _____

Gender Assigned at Birth (check one): M ____ F ____ Identifies As: M ____ F____ Other ____

Preferred Pronouns (check one): He/Him _____ She/Her _____ They/Them _____ Other ____

Parent or Guardian Name(s): _____

Cell Phone #: _____ Home/Alt Phone #: _____

Email Address: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Responsible Party Address (if different than above):

_____

Insurance Name: _____ ID: _____

How did you hear about our clinic? _____

SIGNATURE_____ **DATE:** _____

If you are signing on behalf of the patient, please state your relationship_____