PATIENT REGISTRATION

Please Print

FULL NAME OF EACH CHILD	AGE	BIRTHDATE
1. ______________________	______	______________
2. ______________________	______	______________
3. ______________________	______	______________
4. ______________________	______	______________

MOTHER'S NAME ______________________________ HOME PHONE ______________
LAST FIRST

ADDRESS ______________________________ CELL PHONE ______________

CITY ______________________________ STATE ________ ZIP ______________

EMPLOYER ______________________________ WORK PHONE ______________

DRIVER'S LICENSE# ______________ SS# ______________ DOB ______________

FATHER'S NAME ______________________________ HOME PHONE ______________
LAST FIRST

ADDRESS ______________________________ CELL PHONE ______________

CITY ______________________________ STATE _____ ZIP ______________

EMPLOYER ______________________________ WORK PHONE ______________

DRIVER'S LICENSE# ______________ SS# ______________ DOB ______________

CHILDREN LIVE WITH _______ BOTH PARENTS _______ MOTHER _______ FATHER _____ OTHER

EMERGENCY CONTACT ______________________________ PHONE ______________

ADDRESS ______________________________ RELATIONSHIP ______________

NAME OF SUBSCRIBER ______________________________ DOB ______________

INSURANCE CO. ______________________________

MEMBER ID # ______________________________ GROUP# ______________

REFERRED BY: ______________________________

AUTHORIZATION: **I hereby authorize Dr. Tiffany Becker to furnish information to insurance carriers concerning the illness/accident, and I hereby irrevocably assign to Dr. Becker all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.**

SIGNATURE ______________________________ DATE ______________