Integrative Developmental and Behavioral Pediatrics, LLC

PATIENT REGISTRATION

Patient Name_____DOB_____Gender (M/F)

New or **established** patient? (please circle one)

Parent/Guardian #1_____DOB_____Gender (M/F)

Relationship to patient_____

Address_____Home phone_____

City/State/Zip_____Cell Phone_____

Employer/Occupation_____Work phone_____

Communication by email represents a potential risk to patient confidentiality. By furnishing my email, I consent to the use of email to communicate. Email:_____

Please indicate best way to contact you:_____

Parent/Guardian #2_____DOB_____Gender (M/F)

Relationship to patient_____

Address_____Home phone_____

City/State/Zip_____Cell Phone_____

Employer/Occupation_____Work phone_____

Communication by email represents a potential risk to patient confidentiality. By furnishing my email, I consent to the use of email to communicate. Email:_____

Please indicate best way to contact you:_____

Parent/Guardian #3_____DOB_____Gender (M/F)

Relationship to patient_____

Address_____Home phone_____

City/State/Zip_____Cell Phone_____

Employer/Occupation_____Work phone_____

Communication by email represents a potential risk to patient confidentiality. By furnishing my email, I consent to the use of email to communicate. Email:_____

Please indicate best way to contact you:_____

Patient Name_____ DOB_____

***PLEASE REQUEST "ADDITIONAL PARENTS / GUARDIANS FORM" IF YOU WOULD LIKE TO LIST MORE THAN THREE PARENTS/GUARDIANS**

Parents are: (circle all that apply): Married / Living together / Separated / Divorced / Other

If parents are not married, who is the custodial parent?_____

Sibling Name_____DOB_____Gender (M/F)

Sibling Name_____DOB_____Gender (M/F)

Sibling Name_____DOB_____Gender (M/F)

Sibling Name_____DOB_____Gender (M/F)

Additional siblings_____

Emergency Contact Person_____

Emergency Contact primary phone #_____secondary phone #_____

Who may we thank for referring you to us?_____

Patient Signature (if 14 or older)_____Date_____

Parent/Guardian Signature_____Date_____

Printed name of Parent/Guardian_____

Patient Name_____ DOB_____

Prescription Insurance

Insurance Company_____Policy No._____

Address_____Phone_____Fax_____

Subscriber_____DOB_____

Relationship to Patient_____

Preferred Pharmacy

Name_____Phone #_____

Address_____Fax #_____