Pediatric Registration Information

Sterling Square Primary Care

Patient Information

Patient Name _____ Birth Date ____/____/____
First MI Last

Primary Care Physician _____ Social Security Number _____ Sex _____

Address _____ Home Phone _____
Street City State Zip

How did you hear about our practice? (please circle and/or complete)

Advertisement/Family or Friend _____ / Other _____

Father's Information

Father's Name _____ Social Security Number _____
First MI Last

Address _____ Home Phone _____
Street City State Zip

Employer _____ Work Phone _____

Mother's Information

Mother's Name _____ Social Security Number _____
First MI Last

Address _____ Home Phone _____
Street City State Zip

Employer _____ Work Phone _____

Insurance Information

Insurance: Type of Insurance _____ Agreement / ID Number _____

Policyholder _____ Group Number _____

In case of an emergency please notify: (Other than Parent)

Name _____ Relationship _____
First MI Last

Address _____ Home Phone _____
Street City State Zip

Work Phone _____

General Consent for Treatment of Minors Under Age 18 Years

Patient Name _____

I am the parent or guardian of the above names minor. I voluntarily consent of his/her receipt of medical care of a routine nature from authorized professional staff of the _____ whether or not accompanied by me. I understand that this authorization and consent will not in any way jeopardize me, and that I have the right to a full disclosure of the nature of any medical treatment received or proposed to be rendered and the risks, if any, involved and alternative means available. It is understood that I may withdraw this consent at any time by contacting any member of the professional staff in writing.

Patient Signature _____ **Date Signed** _____

Consolidated Graphic Comunications