KIDS CREEK CHILDREN'S CLINIC PATIENT REGISTRATION FORM Today's Date_____

PATIENT INFORMATION (PLEASE PRINT) □ **New** □ **Update**

Patient's Full Name _____
Last First MI

Date of Birth _____ ☐ Male ☐ Female Social Security #_____

Home Address _____

City, State, Zip _____

Patient's Phone _____ Patient's E-Mail_____

Please Circle
Race: American Indian or Alaska Native, Asian, Native Hawaiian, Black or African American
White, Hispanic, Other Race, Other Pacific Islander, or Decline to Report

Ethnicity: Hispanic, Non-Hispanic, Decline to Report

PARENT OR GUARDIAN INFORMATION (All step parent information in designated box below)

Full Name _____
Last First MI

Date of Birth_____ ☐ Male ☐ Female Social Security #_____

Mailing Address _____

City, State, Zip _____

Home Phone _____Cell Phone_ _____

Work Phone _____Ext_____Employer_____

Relationship to Patient ☐ Parent ☐ Guardian (explain)_____email address_____

PARENT OR GUARDIAN INFORMATION (All step parent information in designated box below)

Full Name _____
Last First MI

Date of Birth _____ ☐ Male ☐ Female Social Security #_____

Mailing Address _____

City, State, Zip _____

Home Phone _____Cell Phone_____

Work Phone _____Ext_____Employer_____

Relationship to Patient ☐ Parent ☐ Guardian (explain) _____ email address_____

PLEASE LIST NAMES OF ALL STEP PARENTS AND SIBLINGS LIVING WITH CHILD

Full Name _____
Last First MI

Date of Birth _____ ☐ Male ☐ Female Relationship to child_____

Full Name _____
Last First MI

Date of Birth _____ ☐ Male ☐ Female Relationship to child _____

Full Name _____
Last First MI

Date of Birth _____ ☐ Male ☐ Female Relationship to child _____
(If more space needed please as for second page)

EMERGENCY CONTACT nearest Friend or Relative not living in your household

Name_____ Home phone_____

Relationship to Patient _____Work phone_____

For New Patients: How did you hear about our office: Friend Family Member Health Care Provider TV Internet Phonebook?
Who may we thank? _____