MINOR REGISTRATION FORM

PLEASE ANSWER ALL QUESTIONS ON THIS FORM. THANK YOU

MINOR'S NAME _____

MAILING ADDRESS _____

CITY _____ STATE _____

ZIP _____ SEX M/F _____

SCHOOL _____

E-MAIL (OPTIONAL) _____

REFERRED BY _____

PRIMARY CARE PHYSICIAN _____

MOTHER'S HOME PHONE _____

FATHER'S HOME PHONE _____

MOTHER'S WORK PHONE _____

FATHER'S WORK PHONE _____

D.O.B. _____ AGE _____

MOTHER'S SOCIAL SECURITY # _____

DRIVERS LIC. # _____ D.O.B. _____

FATHER'S SOCIAL SECURITY # _____

DRIVERS LIC. # _____ D.O.B. _____

CHILD LIVES WITH: *MOTHER* *FATHER* *OTHER*

NEAREST RELATIVE NAME & PHONE _____

_____

_____

MOTHER _____
(OR OTHER GUARDIAN/ RELATIONSHIP TO MINOR)

ADDRESS _____
(IF DIFFERENT THEN CHILD'S)

EMPLOYER _____

FATHER _____
(OR OTHER GUARDIAN/RELATIONSHIP TO MINOR)

ADDRESS _____
(IF DIFFERENT THEN CHILD'S)

EMPLOYER _____

PRIMARY INSURANCE _____

SUBSCRIBER NAME _____

SUBSCRIBER # _____

GROUP # _____

SECONDARY INSURANCE _____

SUBSCRIBER NAME _____

SUBSCRIBER # _____

GROUP# _____

I HEREBY AUTHORIZE PAYMENT FOR MEDICAL BENEFITS TO MYSELF OR THE NAMED PROVIDER FOR PROFESSIONAL SERVICES RENDERED. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

GUARDIAN'S SIGNATURE _____ DATE _____