Today's Date: ______________

## PATIENT INFORMATION

Has the patient been seen at any of The Children's Hospital locations? yes no
Patient's full legal name: (last, first, middle) ______________
Has patient been seen here under a different name? yes no
If yes, give full name: ______________
Date of Birth: ______/______/______ Social Security Number: ______-______-______
Street address: ______________ City: ______________ State: ______ Zip: ______
Home Phone: ______________
Gender: male female Preferred Language for Visits: ______________

**We are asking you questions about your race, ethnicity, and your primary language because we are required to by law since we receive federal funding/assistance. This information will not be used to determine your eligibility for receiving services.**

Race: American Indian or Alaskan Native Asian Black or African American
Native Hawaiian or Other Pacific Islander White More than one race
Refused/Not reported

Who do you take your child to when they are ill or for a regular check up? ______________

## PARENT OR LEGAL GUARDIAN #1

Relationship to patient: ______________ Gender: male female
Full legal name: (last, first, middle) ______________
Date of Birth: ______/______/______ Social Security Number: ______-______-______
Address: (if different from patient) ______________ City: ______________ State: ______ Zip: ______
Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________
Place of Employment: ______________
Employers Address: ______________ City: ______________ State: ______ Zip: ______
Employment status: full time part time unemployed Occupation: ______________

## PARENT OR LEGAL GUARDIAN #2

Relationship to patient: ______________ Gender: male female
Full legal name: (last, first, middle) ______________
Date of Birth: ______/______/______ Social Security Number: ______-______-______
Address: (if different from patient) ______________ City: ______________ State: ______ Zip: ______
Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________
Place of Employment: ______________
Employers Address: ______________ City: ______________ State: ______ Zip: ______
Employment status: full time part time unemployed Occupation: ______________

## EMERGENCY CONTACT (Besides Parent/Legal Guardian)

Name: (last, first, middle) ______________
Relationship to patient: ______________ Phone: ______________

## INSURANCE INFORMATION

**Primary Insurance (first insurance to be billed):** Name of insurance company: ______________
Street Address: ______________ City: ______________ State: ______ Zip: ______
Phone: ______________ Policy #: ______________ Group #: ______________
Name of insured (person who carries the coverage): ______________ Relationship to patient: ______________
Subscriber or Social Security Number: ______________ Subscriber Date of Birth: _____/_____/______

**Secondary Insurance (second insurance to be billed):** Name of insurance company: ______________
Street Address: ______________ City: ______________ State: ______ Zip: ______
Phone: ______________ Policy #: ______________ Group #: ______________
Name of insured (person who carries the coverage): ______________ Relationship to patient: ______________
Subscriber or Social Security Number: ______________ Subscriber Date of Birth: _____/_____/______

The Children's Hospital

Affiliated with

**Pre-Registration Form**