# VA Pediatrics & Adolescent Medicine, PLC
# Patient Registration Form

Please PRINT and Fill Out all Sections

*Patient Information*

| First Name | Last Name | **Date of Birth** | **Sex** | Preferred Name |
|---|---|---|---|---|
| | | | M F NB | |
| | | | M F NB | |
| | | | M F NB | |
| | | | M F NB | |
| | | | M F NB | |

*Parent/Guardian*: ☐Mother ☐Father ☐Stepmother ☐Stepfather ☐Other _____

| Name, First Last | Date of Birth | SSN |
|---|---|---|
| Address 1 | Apt/Unit | Prime Phone # |
| City | State, Zip | Secondary Phone # |
| E-Mail Address | | |

*Parent/Guardian*: ☐Mother ☐Father ☐Stepmother ☐Stepfather ☐Other _____

| Name, First Last | Date of Birth | SSN |
|---|---|---|
| Address | Apt/Unit | Prime Phone # |
| City | State, Zip | Secondary Phone # |
| E-Mail Address | | |

*Emergency Contact*

| Name, First Last | Relation | Phone # |
|---|---|---|
| | | |

*Insurance Information*

| Insurance Name | ID # | Group # |
|---|---|---|
| Policy Holder/Subscriber | Date of Birth | |

*Pharmacy*

| Name | Shopping Center |
|---|---|
| Address | Phone # |
| City, state, Zip | Fax # |

I certify the information I have reported above is correct and will notify VA Pediatrics of any changes.

_____ _____ _____

Signature of Parent/Guardian Print Name Date