



## Complete Children's Health Registration Sheet

<b>Patient Information:</b> (Please include middle initial.)	
Name:	
Chart ID#	Physician:
Social Security #:	DOB:

<b>Bill to Information:</b>		
Name:		
Address:		
Phone:	Social Security #:	DOB:
Employer:	Work Phone #:	

<b>Extended Information:</b> (Other Parent's Information)		
Name:		
Address:		
Home Phone:	Relationship:	
Social Security #:	DOB:	
Employer:	Work Phone #:	

<b>Emergency Contact:</b> (ie Grandparent, Aunt, Uncle or Friend)	
Name:	Relationship:
Home Phone #:	Work Phone:

<b>Insurance Information:</b>	
Policyholder:	
Company:	
Policy #:	Group #:
Effective Date:	

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient: \_\_\_\_\_