

REGISTRATION FOR MINORS

(Please print)

Patient's name: _____ Date of birth _____

Address _____
Street or P.O. Box City State Zip code

Home phone # _____ Social Security # _____

Reason for today's visit? _____
(Indicate body part and right or left)

If injury related, date of injury _____ How did it happen? _____
Where? _____

Auto related? YES or NO If yes, in what state did accident occur? _____

FATHER/SUBSCRIBER INFORMATION

Name: _____ Social Security: _____

Employer _____

Home address (if different than above) _____

Work # _____ Home # _____ Date of Birth: _____

Cell Phone: _____ (Please only provide cell # if you give permission for AOA to call you at this number.)

MOTHER/SUBSCRIBER INFORMATION

Name: _____ Social Security: _____

Employer _____

Home address (if different than above) _____

Work # _____ Home # _____ Date of Birth: _____

Cell phone # _____ (Please only provide cell # if you give permission for AOA to call you at this number.)

Was the patient referred here? Yes No

If yes, name of referring doctor _____

Who is the child's family doctor or pediatrician? _____

Person we can contact in the event of an emergency? (Other than parents)

Name _____ Relationship _____

Daytime phone # _____ Evening phone# _____

It is the policy of this office that the parent/guardian authorizing treatment for a minor will be responsible for payment of this account regardless of insurance status or custody status.

Please initial _____

Today's Date: _____