Lurie Children's Primary Care
Town & Country Pediatrics
Patient Registration

A D M I N S T

Medical Record No.
Patient Name
Birthdate
Physician
Please align patient label to the right

Patient Registration Form

PATIENT INFORMATION			**TODAY'S DATE:**
Last Name:			First Name:
Gender: ☐ Male ☐ Female ☐ Unknown			DOB:
Address:			
City:	State:		Zip:
Sibling:	Gender: ☐ Male ☐ Female ☐ Unknown		DOB:
Sibling:	Gender: ☐ Male ☐ Female ☐ Unknown		DOB:
Sibling:	Gender: ☐ Male ☐ Female ☐ Unknown		DOB:

PARENT/GUARDIAN 1		
Last Name:		First Name:
SS#:		DOB:
Address:		
City:	State:	Zip:
Home Telephone #:		Cell Phone #:
Work Phone #:		Email Address:
PARENT/GUARDIAN 2		
Last Name:		First Name:
SS#:		DOB:
Address:		
City:	State:	Zip:
Home Telephone #:		Cell Phone #:
Work Phone #:		Email Address:

EMERGENCY CONTACT PERSON *(OTHER THAN PARENT)*	
Last Name:	First Name:
Relationship:	DOB:
Home Telephone #:	Cell Phone #:
Work Phone #:	Email Address:

INSURANCE INFORMATION	
Primary Insurance:	Effective Date:
Policy Holder's Name:	
Policy #/ID:	Policy Group:
Claims Address/Phone:	
Secondary Insurance:	Effective Date:
Policy Holder's Name:	
Policy #/ID:	Policy Group:
Claims Address/Phone:	

PREFERRED PHARMACY	**NAME:**		
Address:			
City:	State:	Zip:	Telephone #:

_____ _____
Signature of Patient or Personal Representative Date