MOUNT CARMEL
Medical Group

PATIENT REGISTRATION FORM (MINOR)

OFFICE USE ONLY
NG Account # _____

Name _____ ❑ male ❑ female
Address _____ Apt# _____
City _____ State _____ Zip _____
Birth Date_____ Age _____ Social Security # _____-_____-_____
Student: ❑ yes ❑ no School Name _____
Child lives with: ❑ both parents ❑ mother ❑ father ❑ other _____
Guardian's Name _____
Mother's Name _____
(If Different) Address _____
Home Phone _____ Work Phone _____
Birth Date_____ Age _____ Social Security # _____-_____-_____
Employed: ❑ yes ❑ no Employer _____
Father's Name _____
(If Different) Address _____
Home Phone _____ Work Phone _____
Birth Date_____ Age _____ Social Security # _____-_____-_____
Employed: ❑ yes ❑ no Employer _____

May we leave messages at home with other residents	❑ yes	❑ no
May we leave personal health information on your answering machine/voicemail	❑ yes*	❑ no
May we contact you via e-mail or cellular telephone	❑ yes**	❑ no
May we contact you via text message	❑ yes**	❑ no

**Appointment reminders will be left on voicemail.*
***We cannot ensure the confidentiality of information shared by these means.*

Who may we contact in case of Emergency? Name _____
Relationship _____ Phone #1 _____ #2 _____
Who may we talk to about your child's medical concerns?
Note: *Unless we have legal documents on file restricting access to medical information, both parent's have the right to access a child's medical record. However, we cannot give any info personal health information to anyone other than a parent unless you list him or her by name.*
Name _____ Relationship _____

INSURANCE INFORMATION

Note: *We require that your card be presented at every visit ~ OR~ if card is not available you must verify eligibility, and provide ID#, group #, mailing address & provider services #. If not, you will be responsible for the cost of the office visit.*

Primary Insurance Company_____ Co-payment $_____
Card Holder Name _____ Birth Date _____
Address _____Social Security # _____-_____-_____
Relationship to card holder: ❑ self ❑ mother ❑ father ❑ other

Secondary Insurance _____
Card Holder Name _____ Birth Date _____
Address_____Social Security # _____-_____-_____
Relationship to Card Holder: ❑ self ❑ mother ❑ father ❑ other
Card(s) Copied: Primary: ❑ yes ❑ no Secondary: ❑ yes ❑ no

I understand that when I sign this document that I am confirming that all information completed by me is correct, I authorize contact in the means identified above and that any falsification can lead to my dismissal from this practice.

Signature _____ Today's Date _____

HOW DID YOU HEAR ABOUT US?

❑ 411	❑ HealthCALL	❑ Newspaper	❑ Referring Physician_____
❑ Brochure	❑ Insurance Listing	❑ Radio	❑ Other _____
❑ Drive-By Signage	❑ Phone Book	❑ Shopping Cart	
❑ Family or Friends	❑ Postcard	❑ Website	