



Arboretum Pediatrics

Date Completed: _____

PATIENT REGISTRATION

PATIENT INFORMATION: MRN: _____				ORG MRN: _____					
Patient's Legal Name (<i>Last, First, Middle</i>)						Preferred Name			
Social Security Number			Date of Birth		Sex M F		Home Phone Number		
The child lives with: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Guardian _____									
Parent / Guardian's Name				Parent / Guardian's Name					
Date of Birth		Sex	S.S.N.		Date of Birth		Sex	S.S.N.	
Street Address (<i>Required</i>)				Street Address (<i>Required</i>)				Check if Same <input type="checkbox"/>	
P.O. Box (<i>if applicable</i>)			P.O. Box Zip Code		P.O. Box (<i>if applicable</i>)			P.O. Box Zip Code	
City		State	Zip (+4 if known)		City		State	Zip (+4 if known)	
Home Phone		Cell Phone		Work Phone		Home Phone		Cell Phone	Work Phone
Fax Number				Fax Number					
E-Mail Address:				E-Mail Address:					
Employer Name:				Employer Name:					
Employer Address: (<i>Street Address/P.O. Box</i>)					Employer Address: (<i>Street Address/P.O. Box</i>)				
City		State	Zip (+4 of known)		City		State	Zip (+4 of known)	
Do we have permission to leave a voice message for routine matters such as appointments, pick-ups, and normal lab results? <input type="checkbox"/> Yes <input type="checkbox"/> No									
How would you prefer to receive appointment reminders? (<i>Please choose one</i>) <input type="checkbox"/> Home Telephone <input type="checkbox"/> Mobile Telephone <input type="checkbox"/> Mobile Text <input type="checkbox"/> E-mail _____									

EMERGENCY CONTACT: (<i>Other than Parents or Legal Guardian</i>)		
Name (<i>Last, First, Middle</i>)		Relationship
Home Phone Number	Work Phone Number	Cell Phone Number

