# PATIENT REGISTRATION

**Patients First, Middle, Last:**_____
**Date of Birth:** _____ **Male/Female**_____
**Primary Telephone:**_____ **SS#**_____
**Address:** _____
**City, State Zip:** _____

**CIRCLE ONE FOR EACH:**
**RACE: White American Indian Asian Native Hawaiian African American Hispanic Refuse to Report**

**ETHNICITY: Non-Hispanic Hispanic Latin Refuse to Report**

**Language: English Spanish Other**

## OTHER FAMILY MEMBERS WITHIN OUR PRACTICE:

Siblings:_____D.O.B_____SS#_____
Siblings: _____ D.O.B_____SS#_____
Siblings: _____D.O.B._____SS#_____

## Mother's Information:

First:_____Middle:_____Last:_____D.O.B._____
Maiden Name:_____
Address: _____
City, State Zip: _____
E-mail Address: _____ Home: _____
Social Security #: _____ Cell: _____
Employer, Address and Phone: _____
_____

## Father's Information:

First:_____Middle:_____Last:_____D.O.B_____
Address: _____
City, State Zip: _____
E-mail Address: _____ Home: _____
Social Security #:_____ Cell: _____
Employer, Address and Phone: _____
_____

## INSURANCE INFORMATION

Primary Insurance ID Number: _____
Policy Holders Name: _____

Secondary Insurance ID Number: _____
Policy Holders Name: _____

# PATIENT REGISTRATION

## PHARMACY

**FIRST CHOICE:** _____

**SECOND CHOICE:** _____

**Permission to obtain electronic medication history from pharmacy: Yes No**

**WHO HAS PERMISSION TO BRING YOUR CHILD TO AN APPOINTMENT AND EMERGENCY CONTACT? LIST SOMEONE OTHER THAN PARENT:**

**1:**
**Name:** **Relationship to patient:**
**Address:**

**Home:**
**Cell:**
**Authorized to Make Medical Decisions: Yes No**
**Authorized to Give Permission to Immunizations: Yes No**
**Emergency Contact: Yes No**

**2:**
**Name:** **Relationship to patient:**
**Address:**

**Home:**
**Cell:**
**Authorized to Make Medical Decisions: Yes No**
**Authorized to Give Permission to Immunizations: Yes No**
**Emergency Contact: Yes No**

## CONSENT:

The above information is true to the best of my knowledge. I give consent for treatment and authorization that my insurance benefits be paid directly to John M. Gorlowski, M.D., P.C. I understand that I am financially responsible for any balance or service not covered by my insurance company. I authorize the Group and/or the Insurance Company to release any information required to process my claim. I also authorize a copy of this Consent to be used in lieu of the original. I further authorize the release of private health information to other providers and/or pharmacies involved in my child's care.

_____ _____

Parent/Guardian Signature Date