# Sun City Kidz Clinic

## New Patient Registration

PRIMARY LANGUAGE SPOKEN_____ DOCTOR YOU ARE HERE TO SEE? _____

## PATIENT INFORMATION

NAME _____ DOB _____
(LAST) (FIRST) (MIDDLE)

ADDRESS _____
(STREET) (APT) (CITY) (STATE) (ZIP)

SEX : MALE FEMALE WAS PATIENT PREMATURE? YES NO IF YES, HOW MANY WEEKS? _____

RACE (SELECT ONE): Decline to State

ETHNICITY (SELECT ONE): Decline to Stae

## PARENTS(S) OR GUARDIAN(S) INFORMATION

PARENTS MARITAL STATUS? ☐ MARRIED ☐ UNMARRIED ☐ WIDOWED ☐ OTHER _____

WHO DOES PATIENT LIVE WITH? ☐ BOTH PARENTS ☐ MOTHER ☐ FATHER ☐ OTHER _____

FIRST CONTACT'S RELATIONSHIP TO PATIENT ☐ MOTHER ☐ FATHER ☐ GRANDPARENT ☐ OTHER _____

NAME _____ DOB _____ SS # _____
(LAST) (FIRST)

ADDRESS _____
(STREET) (APT) (CITY) (STATE) (ZIP)

CHECK PREFERRED NUMBER: □HOME PHONE: (_____)_____ □CELL PHONE: (____)_____

PLACE OF EMPLOYMENT: _____ WORK PHONE: (____)_____

SECOND CONTACT'S RELATIONSHIP TO PATIENT ☐ MOTHER ☐ FATHER ☐ GRANDPARENT ☐ OTHER _____

NAME _____ DOB _____ SS # _____
(LAST) (FIRST)

ADDRESS _____
(STREET) (APT) (CITY) (STATE) (ZIP)

CHECK PREFERRED NUMBER: □HOME PHONE: (_____)_____ □CELL PHONE: (____)_____

PLACE OF EMPLOYMENT: _____ WORK PHONE: (____)_____

## INSURANCE INFORMATION (PLEASE PROVIDE COPIES OF ALL INSURANCE CARDS)

PRIMARY INSURANCE _____ POLICY HOLDER _____
POLICY HOLDER RELATIONSHIP TO PATIENT _____ DOB _____

SECONDARY INSURANCE _____ POLICY HOLDER _____
POLICY HOLDER RELATIONSHIP TO PATIENT _____ DOB _____

## EMERGENCY CONTACT

NAME #1 _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____

PHONE (____)_____ HOME/MOBILE/WORK PHONE (____)_____ HOME/MOBILE/WORK

NAME #2 _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____

PHONE (____)_____ HOME/MOBILE/WORK PHONE (____)_____ HOME/MOBILE/WORK

## PHARMACY INFORMATION (THIS IS WHERE ELECTRONIC SCRIPTS WILL BE SENT)

NAME OF PHARMACY _____

CROSS STREETS (EXAMPLE: MESA & BALTIMORE) _____

## SIBLING NAMES (IF ANY)

NAME _____ DATE OF BIRTH _____

NAME _____ DATE OF BIRTH _____

NAME _____ DATE OF BIRTH _____

NAME _____ DATE OF BIRTH _____

HOW DID YOU HEAR ABOUT OUR CLINIC? _____

## PARENTAL CONSENT FOR TREATMENT

I grant the physicians at Sun City Kidz Clinic permission to medically treat my child as they deem necessary.

_____ _____

PARENT/GUARDIAN SIGNATURE RELATIONSHIP TO PATIENT

_____ _____

PRINT NAME DATE

## CONSENT FOR OTHERS TO BRING CHILD TO CLINIC

In accordance with Texas Law, Sun City Kidz Clinic will not provide health care to minors unless a parent accompanies them, a parent provides written consent, or a way is provided for the clinic to contact the parent.

In Texas, a patient is considered a "minor" if he/she is under 18 years of age, has never married, or has not been declared a legally emancipated minor.

I authorize the following individuals to seek medical treatment for the following child in my absence.

NAME #1 _____ RELATIONSHIP TO PATIENT _____
PHONE NUMBER (____)_____
MAY THIS INDIVIDUAL APPROVE/SIGN FOR VACCINE ADMINISTRATION? (INITIAL ONE) _____ YES _____NO

NAME #2 _____ RELATIONSHIP TO PATIENT _____
PHONE NUMBER (____)_____
MAY THIS INDIVIDUAL APPROVE/SIGN FOR VACCINE ADMINISTRATION? (INITIAL ONE) _____ YES _____NO

_____ _____

PARENT/GUARDIAN SIGNATURE RELATIONSHIP TO PATIENT

_____ _____

PRINT NAME DATE