Barrett Clinic P.C.
PRIMARY & PREVENTATIVE HEALTHCARE

Adolescent Patient Registration **Today's Date: _____**

Child #1: First Name: _____ MI: ____ Last Name: _____

Nickname: _____ Sex: ☐ Female ☐ Male Date of Birth: _____

Child #2: First Name: _____ MI: ____ Last Name: _____

Nickname: _____ Sex: ☐ Female ☐ Male Date of Birth: _____

Child #3: First Name: _____ MI: ____ Last Name: _____

Nickname: _____ Sex: ☐ Female ☐ Male Date of Birth: _____

Address: _____ City:_____ ST:___ Zip: _____

Who does the adolescent live with? _____

Parent/Guardian Information:

Mother: First Name: _____ Last Name: _____

Address: _____ City:_____ ST:___ Zip: _____

		Yes	No
Home Phone: (____)_____	May we leave a detailed message:	☐	☐
Cell Phone: (____)_____	May we leave a detailed message:	☐	☐
	Consent to call/text:	☐	☐
Work Phone: (____)_____	May we leave a detailed message:	☐	☐

Employer: _____ Employer address: _____

Father: First Name: _____ Last Name: _____

Address: _____ City:_____ ST:___ Zip: _____

		Yes	No
Home Phone: (____)_____	May we leave a detailed message:	☐	☐
Cell Phone: (____)_____	May we leave a detailed message:	☐	☐
	Consent to call/text:	☐	☐
Work Phone: (____)_____	May we leave a detailed message:	☐	☐

Employer: _____ Employer address: _____

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Emergency Contact: _____ Phone: (_____)_____

Relationship to Patient: _____

Preferred Pharmacy: _____ Location: _____

Phone: (_____)_____

How did you hear about Barrett Clinic? _____

Do you give the staff at Barrett Clinic permission to speak to anyone other than the parents/guardian listed above about your child's healthcare? ☐ No

☐ Yes, list name and relationship: _____

_____

Insurance

Primary Insurance: _____

Policy Holder Name: _____ Date of Birth: _____

Address of Policy holder:_____ City: _____ St: _____ Zip: _____

Phone: (_____)_____ SSN: _____

Employer: _____ Relationship to patient: _____

Secondary Insurance: _____

Policy Holder Name: _____ Date of Birth: _____

Address of Policy holder:_____ City: _____ St: _____ Zip: _____

Phone: (_____)_____ SSN: _____

Employer: _____ Relationship to patient: _____