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: ________________

Primary Language spoken: ☐ English ☐ other, specify _____________

Ethnicity: Is your child Hispanic/Latino? ☐ Yes ☐ No

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ White

Child #2: First Name: ______________________ MI: ____ Last Name: _________________________

Nickname: ___________________ Sex: ☐ Female ☐ Male Date of Birth: ________________

Primary Language spoken: ☐ English ☐ other, specify _____________

Ethnicity: Is your child Hispanic/Latino? ☐ Yes ☐ No

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ White

Emergency Contact: _____________________ Phone: (______)____________________

Relationship to Patient: ________________________________

Preferred Pharmacy: ____________________ Location: ____________________

Phone: (______)___________________

Who does the adolescent live with? ____

Parent/Legal 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: __________________________

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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: ____________________________

Insurance

Primary Insurance: ____________________________

☐ Card provided **OR complete:**

Policy Holder Name: ________________________ Date of Birth: __________________________

Address of Policy holder:_______________________ City: ____________ St: _______ Zip: _____

Phone: (_______)______________________ SSN: ________________________________

Employer: _______________________ Relationship to patient: _______________________

Secondary Insurance: ____________________________

☐ Card provided **OR complete:**

Policy Holder Name: ________________________ Date of Birth: __________________________

Address of Policy holder:_______________________ City: ____________ St: _______ Zip: _____

Phone: (_______)______________________ SSN: _________________________________

Employer: _______________________ Relationship to patient: _________________________

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

☐ Yes, list name and relationship: ____

____

____ ___________________________

Signature of Parent/LAR/Power of Attorney/Guardian Date