brighton pediatrics

Patient Registration

Patient Last Name_____ **Patient First Name**_____ **MI**_____

Sex_____ **DOB**_____ **Social Security Number**_____

Mailing Address_____

City_____ **State**_____ **Zip Code**_____

Primary Language Spoken in Home _____

	Mother	Father
Name:		
DOB:		
SS#:		
Employer:		
Cell Phone:		
Email:		
Primary Contact:	Yes/No	Yes/ No
Preferred Contact Method for Well Visit Appt Reminders:	Text Cell/Call Cell	Text Cell/Call Cell

	Primary Insurance	Secondary Insurance
Policyholder		
Relationship to Patient		
Insurance Company		
Policy #		
Group #		

Emergency Information (EXCLUDING PARENTS):

Name_____ **Relationship**_____

Cell Phone _____ **Work Phone**_____ **Home Phone**_____

Signature of Responsible Party_____ **Date**_____