Rachel Z. Chatters, MD
Patient Registration

Patient Information:

Last Name: _____ First Name: _____ MI: _____
Date of Birth: __/___/_____ Social Security Number: _____ Sex: Male/Female
Primary Language: _____
Ethnicity: Hispanic / Non-Hispanic / Unknown *Race:* Asian / Black / Hawaiian / White
Primary Address: _____ _____ _____
(Street or PO Box) (City) (State & Zip)

Primary Phone: (____) _____ - _____.

Who lives at this household? _____

Pharmacy Name: _____ Pharmacy Location: _____

Family Contact Information:

Mother's Name: _____ Date of Birth: ___/__/____ SSN:_____
Biological Mother: Yes___ No___ Lives with Patient: Yes___ No___
Work Phone: (____) _____ - _____.____ Cell Phone: (____) _____ - _____.
Home Email: _____ Work Email: _____
Employer: _____ Occupation: _____
Access to the patient's records electronically? Yes___ No ____

How would you prefer to be contacted regarding (check one per line)
Recall Notices: Home Phone__ Work Phone __ Cell Phone __ Home Email __ Work Email__
General Notices: Home Phone__ Work Phone __ Cell Phone __ Home Email __ Work Email__
Patient Portal Notifications: Home Phone__ Work Phone __ Cell Phone __ Home Email __ Work Email__
Appoint Reminders: Home Phone__ Work Phone __ Cell Phone __ Home Email __ Work Email__

Father's Name: _____ Date of Birth: ___/__/____ SSN:_____
Biological Father: Yes__ No__ Lives with Patient: Yes__ No__
Work Phone: (____) _____ - _____.____ Cell Phone: (____) _____ - _____.
Home Email: _____ Work Email: _____
Employer: _____ Occupation: _____
Access to the patient's records electronically? Yes___ No ____

**If the Non Domiciliary parent will need to be notified for: medical issues, Appointment reminders, recall notices, billing statements, general practice notices and patient portal notifications list their preferences here
_____

Additional Contact Questions:

Who should receive electronic billing statements: Name: _____
Email Address: _____
If parents are divorced, separated or unmarried please fill out this section:
Who has custody? _____
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes____ No_____
If Yes, please explain and provide a copy of any legal paperwork that supports this restriction.
_____

Emergency Contacts: (other than parents)

1. Name:_______________________________________ Relationship:_________________________________
   Phone: ______________________________________

2. Name:_______________________________________ Relationship:_________________________________
   Phone: ______________________________________

Siblings Information:

Sibling Last Name: ___________________________ First Name: ___________________________ MI: _____
Date of Birth: __/___/______ Social Security Number: ______________________ Sex: Male/Female
Primary Language: _____________ *Ethnicity:* Hispanic / Non-Hispanic / Unknown *Race:* Asian / Black / Hawaiian / White
Mother's Name:___________________________________ Father's Name:______________________________

Last Name: ___________________________ First Name: ___________________________ MI: _____
Date of Birth: __/___/______ Social Security Number: ______________________ Sex: Male/Female
Primary Language: _____________ *Ethnicity:* Hispanic / Non-Hispanic / Unknown *Race:* Asian / Black / Hawaiian / White
Mother's Name:___________________________________ Father's Name:______________________________

Last Name: ___________________________ First Name: ___________________________ MI: _____
Date of Birth: __/___/______ Social Security Number: ______________________ Sex: Male/Female
Primary Language: _____________ *Ethnicity:* Hispanic / Non-Hispanic / Unknown *Race:* Asian / Black / Hawaiian / White
Mother's Name:___________________________________ Father's Name:______________________________

Last Name: ___________________________ First Name: ___________________________ MI: _____
Date of Birth: __/___/______ Social Security Number: ______________________ Sex: Male/Female
Primary Language: _____________ *Ethnicity:* Hispanic / Non-Hispanic / Unknown *Race:* Asian / Black / Hawaiian / White
Mother's Name:___________________________________ Father's Name:______________________________

Insurance:

Primary Policy:
Policy Holder's Name: ____________________________________ Policy Holder's Date of Birth: ____ /____/______
Policy Holder's SSN: __________________________________ Policy Holder's Sex: Male/ Female
Insurance Carrier: ____
Insurance ID Number: ____________________________ Group Number: __________________________

Secondary Policy:
Policy Holder's Name: ____________________________________ Policy Holder's Date of Birth: ____ /____/______
Policy Holder's SSN: __________________________________ Policy Holder's Sex: Male/ Female
Insurance Carrier: ____
Insurance ID Number: ____________________________ Group Number: __________________________

Medical History

Previous Physician**:**_____

Birth History:

Place of Birth:_____ _____
(Hospital Name/Other Location) (City & State)

Birth Weight: _____ lbs _____oz. Delivery: Vaginal / C-Section Was Child Premature? Yes / No
Complications?_____
_____

O.B. Doctor: _____

Hospitalizations: (Date/Hospital/Reason)

_____
_____
_____

Surgeries/Injuries/Serious Illnesses:

_____
_____

Child's Allergies:

Medications:_____
Food/Other:_____

Medications: (Name & Dosages)

_____
_____

Child's Health History: (Please circle if the child has had any of the following)

ADD/ADHD	Chest Pain	Excessive Hunger/Thirst	Nose bleeds	Wheezing
Allergies	Constipation	Frequent Urination	Poor Appetite	Whooping Cough
Anemia	Depression	Headaches	Prematurity	Other: _____
Autism	Diarrhea	Hearing Loss	Rash	_____
Bedwetting	Dizziness	HIV/AIDS	Sickle Cell Disease	_____
Bronchitis	Ear Infections	Measles	Vision Problems	_____
Chicken Pox	Easy Bruising	Mumps	Weight Loss/Gain	_____

Family History: (please check that any relatives have & their relationship to the patient)

____ Alcoholism	_____	____ Heart Disease	_____
____ Allergies	_____	____ High Blood Pressure	_____
____ Anemia	_____	____ HIV/AIDS	_____
____ Asthma	_____	____ Kidney Disease	_____
____ Autism	_____	____ Lung Disease	_____
____ Birth Defects	_____	____ Mental Illness	_____
____ Blood Disorder	_____	____ Seizure Disorder	_____
____ Cancer	_____	____ Sickle Cell	_____
____ Diabetes	_____	____ Stroke	_____
____ Epilepsy	_____	____ Thyroid Disease	_____
____ Genetic Defects	_____	____ Tuberculosis	_____
____ Hearing/Vision Loss	_____		

Patient's Name: _____ Date of Birth: ____/_____/_____

Guardian's Signature:_____ Date:_____