RAINBOW PEDIATRICS
PATIENT REGISTRATION FORM

Please note: This information may be used to contact you in an emergency regarding your child. ***Please give us as complete information as possible.*** Thank you!

PATIENT NAME: _____ DOB: _____ SEX: _____

S.S. # _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PARENTS AND RELATIONSHIP TO CHILD (IF APPLICABLE) (e.g.: biological, adoptive, step, foster, guardian, grandparent, etc)

#1_____

HOME PHONE: _____WORK PHONE: _____ CELL PHONE: _____

#2 _____

HOME PHONE: _____WORK PHONE: _____ CELL PHONE: _____

#3 (IF APPLICABLE): _____ PHONE: _____

#4 (IF APPLICABLE): _____ PHONE: _____

EMERGENCY CONTACT: **_____** **EMERGENCY PHONE**: **_____**
(OTHER THAN PARENTS)

RELATIONSHIP TO PATIENT: _____

_____ _____
Signature of Parent or Guardian Date