LIFEBRIDGE PEDIATRICS AT LUTHERVILLE

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PATIENT REGISTRATION FORM

Registration Information – Please Print		
Patient's Legal Name (First, Middle Initial, Last):	Preferred Name:	
Date of Birth:	Gender At Birth: Male ☐ Female ☐	
Preferred Pronoun: He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐		
Home Address:	City:	State/Zip:
List Additional Siblings:		
Patient's Legal Name (First, Middle Initial, Last)	Preferred Name:	
Date of Birth:	Gender At Birth: Male ☐ Female ☐	
Preferred Pronoun: He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐		
Patient's Legal Name (First, Middle Initial, Last)	Preferred Name:	
Date of Birth:	Gender At Birth: Male ☐ Female ☐	
Preferred Pronoun: He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐		
Patient's Legal Name (First, Middle Initial, Last)	Preferred Name:	
Date of Birth:	Gender At Birth: Male ☐ Female ☐	
Preferred Pronoun: He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐		
Parent/Legal Guardian Information		
Full Legal Name (First, Middle Initial, Last):	Date of Birth:	
Preferred Pronoun: He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐		
Home Address:	City:	State/Zip:
Home Phone:	Cell Phone:	Email:
Parent/Legal Guardian Information		
Full Legal Name (First, Middle Initial, Last)	Date of Birth:	
Preferred Pronoun: He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐		
Home Address:	City:	State/Zip:
Home Phone:	Cell Phone:	Email:

Emergency contact person *(Someone other than Parents)	
Name:	Date of Birth:
Relation to Patient:	Phone Number:

Insurance Information:		
Primary Insurance Company Name:		Effective Date:
Name of Policy Holder:	Policy Holder's DOB:	Relation to Patient:
Policy ID#:	Group#:	
Secondary Insurance Company Name:		Effective Date:
Name of Policy Holder:	Policy Holder's DOB:	Relation to Patient:
Policy ID#:	Group#:	
Name of the Guarantor:(Who the bills are sent to)		

Persons Authorized to Accompany and Provide Consent for Treatment Other Than Parents:		
Name:	Relation to Patient:	Phone:
Name:	Relation to Patient:	Phone:

Signature:
Date:
Person Signing, if not Patient:
Person Signing, Relationship, If not Patient: Parent ☐ Stepparent ☐ Guardian ☐