OSF MEDICAL GROUP

# MINOR REGISTRATION FORM

**(Please Print)**

## MINOR PATIENT INFORMATION

| Legal Name: (Last, First, Middle) | AKA/Nickname: | Telephone: ☐ Home ☐ Cell ☐ Work ☐ Other: ( ) | Alternate Telephone: ☐ Home ☐ Cell ☐ Work ☐ Other: ( ) |
|---|---|---|---|

| Sex: ☐ Male ☐ Female | Date of Birth: | Social Security Number: | Email Address: |
|---|---|---|---|

| Street Address: | City: | State: | Zip: | County: |
|---|---|---|---|---|
| Mailing Address (If different): | City: | State: | Zip: | County: |

*Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White/Caucasian ☐ Other ☐ Unknown

*Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Unknown

| Primary Language (If not English): | Hospital Born In: | **Religion Preference: | **Place of Worship: |
|---|---|---|---|

*** This information is requested but not required.**

**** We collect this information to better understand your cultural and religious beliefs when it comes to your medical care.**

## OTHER CHILDREN (TO REGISTER AT THIS PRACTICE FOR FUTURE CARE)

| Legal Name: | Social Security Number: | Date of Birth: | Sex: ☐ Male ☐ Female |
|---|---|---|---|
| Legal Name: | Social Security Number: | Date of Birth: | Sex: ☐ Male ☐ Female |
| Legal Name: | Social Security Number: | Date of Birth: | Sex: ☐ Male ☐ Female |

Do all children live at the same address as above? ☐ Yes ☐ No (If No, please provide address below)

## PARENT / GUARDIAN INFORMATION

| Mother's Name: | Date of Birth: | Social Security Number: |
|---|---|---|
| Telephone: ☐ Home ☐ Cell ☐ Work ☐ Other: ( ) | Alternate Telephone: ☐ Home ☐ Cell ☐ Work ☐ Other: ( ) | |
| Employer Name: | Employer Telephone: ( ) | Ext: |
| Employer Address: | City: State: | Zip: |
| Father's Name: | Date of Birth: | Social Security Number: |
| Telephone: ☐ Home ☐ Cell ☐ Work ☐ Other: ( ) | Alternate Telephone: ☐ Home ☐ Cell ☐ Work ☐ Other: ( ) | |
| Employer Name: | Employer Telephone: ( ) | Ext: |
| Employer Address: | City: State: | Zip: |

***Please see reverse side***

## PARENT / GUARDIAN INFORMATION (Continued)

| | | |
|---|---|---|
| Legal Guardian's Name: | Date of Birth: | Social Security Number: |
| Telephone: ☐ Home ☐ Cell ☐ Work ☐ Other: ( ) | Alternate Telephone: ☐ Home ☐ Cell ☐ Work ☐ Other: ( ) | |
| Employer Name: | Employer Telephone: ( ) | Ext: |
| Employer Address: | City: State: | Zip: |
| Child Lives With: ☐ Parents ☐ Mother ☐ Father ☐ Other | | |

## EMERGENCY / OTHER CONTACT INFORMATION (Please provide the name of a local friend or relative not living at the same address)

| | |
|---|---|
| Emergency Contact Name: | Relationship: |
| Telephone: ☐ Home ☐ Cell ☐ Work ☐ Other: ( ) | Alternate Telephone: ☐ Home ☐ Cell ☐ Work ☐ Other: ( ) |

## GUARANTOR INFORMATION (Individual responsible for payment if other than self)

Who is Responsible for this Guarantor Account:
☐ Self ☐ Mother ☐ Father ☐ Spouse ☐ Other

| | | | | |
|---|---|---|---|---|
| Legal Name: | Telephone: ( ) | Social Security Number: | Date of Birth: | Sex: ☐ Male ☐ Female |
| Street Address: | City: | State: | Zip: | |
| Mailing Address (if different): | City: | State: | Zip: | |
| Guarantor Employer Name: | Telephone: ( ) | Ext: | | |
| Employer Address: | City: | State: | Zip: | |

Employment Status:
☐ Full-time ☐ Part-time ☐ Student Full Time ☐ Student Part Time ☐ Retired (Date: ) ☐ Self-Employed ☐ Active Military ☐ Unemployed

## PATIENT INSURANCE INFORMATION (Please provide your insurance card(s) so a copy can be made for your records)

❶ Primary Insurance Name: (Such as: Medicare, Medicaid or Commercial Insurance Name)

| | |
|---|---|
| Policy #, Medicare #, or Medicaid #: | Group/Certificate #: |
| Subscriber Name (if different): | Subscriber Sex: ☐ Male ☐ Female |
| Relationship To Insured: ☐ Child ☐ Spouse ☐ Self ☐ Other | Subscriber Date of Birth: |

❷ Secondary Insurance Name: (Such as: Medicare, Medicaid or Commercial Insurance Name)

| | |
|---|---|
| Policy #, Medicare #, or Medicaid #: | Group/Certificate #: |
| Subscriber Name (if different): | Subscriber Sex: ☐ Male ☐ Female |
| Relationship To Insured: ☐ Child ☐ Spouse ☐ Self ☐ Other | Subscriber Date of Birth: |

Thank you for choosing OSF MEDICAL GROUP