WELCOME TO OAK MILL PEDIATRICS

PATIENT REGISTRATION FORM

PATIENT INFORMATION				
Patient's Last Name:	Name:	Middle:	Gender:	Birth Date: Month/Day/Year
Social Security No.:	Preferred Language:	Home Phone No.:	Student: ☐ Part Time ☐ Full Time	
Street Address:	City:	State:	Zip Code:	
Race: ☐ White ☐ Hispanic ☐ African American/Black	☐ Asian ☐ Native American ☐ Native Hawaiian	☐ Other Pacific Islander ☐ Other Race ☐ Unreported/Refused	Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Refused to Report	

MOTHER / GUARDIAN		
Last Name:	First:	
Gender:	Birth Date:	Social Security No.:
Cell Phone No.:	Email Address:	
Address:		
Employer:	Work No.:	

OTHER PARENT / GUARDIAN		
Last Name:	First:	
Relationship to Patient: ☐ Father ☐ Other: ________	Birth Date:	Gender:
Cell Phone No.:	Social Security No.:	
Address:		
Employer:	Work No.:	

INSURANCE SUBSCRIBER INFORMATION		
Person Responsible for Account:	Birth Date:	Social Security No.:
Cell Phone No.:	Address:	
Insurance Company:	Employer:	Business Phone:

CURRENT MEDICATION

Name Of Medication	Dose	Frequency Taken	Reason Taken	Perscribing Physician

ALLERGIES

To Antibiotics / Medication:

To Food / Other:

EMERGENCY CONTACT

Name Of Relative

Relationship to Patient

Phone Number

PHARMACY

Name

Address

Phone Number

Whom May We Thank For Referring You?

Electronic Perscriptions: *Our electronic medical record program accesses your perscription/medication history in order for us to safely perscribe your medication. By signing this, you authorize us to do so.*

Immunizations: *Our electronic medical record program allows for your immunization data to be sent directly to the I-CARE State of Illinois Registry. I-CARE allows your providers to obtain your immunization history to ensure your safety. By signing this, you authorize us to submit this data.*

Signature: ____________________________________ *Date:* ____________

Parent / Guardian *Relationship To Patient*