# Family Practice Associates

Fax (501) 778-1013 Phone (501) 778-0934

**Preferred Physician:**
Morgan Chow Cathcart Albey
Wright-Pollich Barker Dixon Mabry Curtis

## Minor Patient Registration Information

### Patient's Personal Information

Name: _____ SS#: ____ - ____ -_____ Date of Birth: __ / __ / ____
Last First MI
Sex: M / F Primary phone #: (_____)_____ Alternate phone #: (_____)_____

Primary E-mail:_____

Child's Primary Address: _____ City: _____ State:_____ Zip:_____

Mother or Parent One Name:_____ Cell Phone #:(_____)_____ SS#:_____-_____-_____

Father or Parent Two Name:_____ Cell Phone #: (_____)_____ SS#:_____-_____-_____

**Race:** White African American Asian Other
Native American Indian/Alaskan Decline to answer
Native Hawaiian/Other Pacific Islander

**Ethnic Group:** Not Hispanic/ Latino
Hispanic/Latino
Decline to answer

**Primary Language:** English
Spanish
Other

**Emergency Contact—Someone not with child and with an alternate number**

Name:_____ Relationship:_____

Best Phone: (___)_____ Alternate Phone: (___)_____

**Preferred Pharmacy**

Name: _____

Phone #:_____

### Guarantor Information (Person responsible for child's bills) Relationship to patient: □ Father □ Mother □ Other_____

Name: _____ SS#: ____ - ____ -_____ DL#: _____
Last First MI
Date of Birth: ___ / ___ / ____ Main phone#: (___)_____ Alternate phone: (___)_____

Address: _____ Apt#: _____ City: _____ State:_____ Zip:_____

Employer:_____ Work phone: (___)_____ Occupation:_____

### Patient's Insurance Information

**Primary** Insurance Company: _____ ID#: _____ Group#:_____

Subscriber Name: _____ Date of Birth: ___ / ___ / ____ Main phone#: (___)_____

Subscriber's relationship to patient: □ Self □ Father □ Mother □ Other_____ Copay: $_____

**Secondary** Insurance Company:_____ ID#:_____Group#:_____

Subscriber Name: _____ Date of Birth: ___ / ___ / ____ Main phone#: (___)_____

Subscriber's relationship to patient: □ Self □ Father □ Mother □ Other_____ Copay: $_____

I request that payment of authorized insurance benefits be made on my child's behalf to the provider indicated above for services furnished to my child. I authorize any holder of medical information about my dependent to release to the insurance company any information needed to determine these benefits or the benefits payable for related services. A photocopy of this assignment is to be considered as the original. I understand that I am financially responsible for all charges whether or not covered by said insurance. This assignment will remain in effect until revoked by me in writing. I further agree to pay the cost of collection, court costs, and other reasonable fees should they be required in the event of my non-payment. (The parent signing this form will be financially responsible for the child. Any legal agreement, or other disagreement, between parents in a divorce situation must be dealt with between those parties and does not involve Family Practice Associates.)

_____ _____
Parent/Legal Guardian Signature Date