

REGISTRATION FORM
INFANT, CHILD OR TEEN (age 18 or younger)

ROOTS WELLCARE, P.A.

Child/Teen's Name _____ Date _____
Birth Date _____ Age _____ Sex _____
Social Security number of child (if available) _____

Parent or Guardian Information:

Name _____

Address _____

Street

City/State

Zip

Phone _____

Home

Work

Cell

Pager

Email address _____

Parent/Guardian Birth Date _____ Age _____ Sex _____

Parent/Guardian Occupation or nature of your work _____

Retired or semi-retired? _____

Marital status: single married divorced separated
(circle) widowed committed relationship

If married/partnered, spouse/partner's name _____ Birth date _____

Spouse/Partner's Occupation _____ Employer _____

Work Phone _____

If divorced or separated, please give name of parent not living with child:

Name _____

Street Address _____

City, State, Zip _____

Other Information:

Emergency Contact _____ Phone _____

(person other than spouse/partner)

Pediatrician/Medical Clinic _____ Phone _____

Whom may we thank for referring you? _____