Riverpoint Psychiatric Assoc.- CHILD Patient Registr. (under 18 yrs) Date:_____

Patient's Name: _____ Sex: M__ F__
first middle last

EMAIL address:_____

Address: _____ City: _____ State: __ Zip: _____

Birthdate: _____ Social Sec. #: _____Referred by: _____

Emergency contact: _____*Relat. to patient:* _____

Address: _____ *Phone: home* _____ *work* _____ *cell* _____

Parent information:

Mother: _____
name address phone #'s: home/work/cell

Soc sec #: _____Employer & address: _____

Father: _____
name address phone #'s: home/work/cell

Soc. Sec. #: _____ Employer & address:_____

Insurance Info:
#1 Company name: _____ Subscriber #: _____Group #: _____

Subscriber's name: _____ Relationship to patient: _____

REQUIRED: Subscriber's date of birth: _____ Subscriber's gender: M __ F __

Person responsible for bill:

_____ _____
(name) (address)

Soc sec #: _____ Phone #: Home: _____ Work: _____ Cell: ____

Race: Asian__ Black __ White __ Other (specify) _____
Ethnicity: African-American__ American__ Chinese__ Filipino__ Hispanic__
Japanese__ Korean__ Mexican__ Puerto Rican__ Other (specify) _____
Language: English_ Spanish_ Other (specify) _____