# CHILD'S PATIENT REGISTRATION FORM
**for Dr. Mary Danielak**

Today's Date_____

## PATIENT INFORMATION

| **First Name:** | **Last Name** | **MI** | **Birth Date:** | **Age:** |
|---|---|---|---|---|
| Street: | | | **School**: | |
| City: | State | Zip | **Grade:** | |
| Home Phone: | | | Male: _____ Female:_____ | |
| **Mom Cell phone:** | **Dad Cell Phone** | | | |
| **Mom email:** | **Dad email:** | | | |
| Parent Name: | Parent Name: | | | |
| Marital Status: | Marital Status: | | | |
| Employed By: | Employed By:: | | | |
| Job Title: | Job Title: | | | |
| City | City | | | |

## LIVING SITUATION – Family Members

Name_____Relationship_____Age_____Live at home Y/N

Name_____Relationship_____Age_____Live at home Y/N

Name_____Relationship_____Age_____Live at home Y/N

Name_____Relationship_____Age_____Live at home Y/N

Name_____Relationship_____Age_____Live at home Y/N

## REFERRAL INFORMATION

Name: _____ Address: _____

City: _____ State:_____ Zip: _____ Phone: _____

Permission to thank source for the referral? Yes_____ No_____
Permission to talk by phone to referral source for information regarding your treatment? Yes_____ No_____
Permission to discuss information regarding my treatment with any additional person(s):

_____

Name Relationship Phone Number

## PHYSICIAN MOST OFTEN SEEN:

Name: _____ Type of physician:_____ Phone: _____

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

## CURRENT MEDICATIONS:

1. Drug Name: _____ Dosage:_____ Started on: _____
   Taking drug for treatment of: _____ Prescribed by: _____

2. Drug Name: _____ Dosage:_____ Started on: _____
   Taking drug for treatment of: _____ Prescribed by: _____

3. Drug Name: _____ Dosage:_____ Started on: _____
   Taking drug for treatment of: _____ Prescribed by: _____