Laurel Health School Based Mobile Health Center
Patient Registration Form

Date:

Patient Information (Please Print)			
(First Name) (Middle) (Last)			DOB: MM/DD/YYYY
Address	City	State	Zip
Email	Home Phone	Work Phone	Cell Phone

Parent/Guardian Information			
(First Name) (Middle) (Last)			Relationship
Email	Home Phone	Work Phone	Cell Phone
(First Name) (Middle) (Last)			Relationship
Email	Home Phone	Work Phone	Cell Phone
(First Name) (Middle) (Last)			Relationship
Email	Home Phone	Work Phone	Cell Phone

Insurance Information		
Primary Insurance Company Name	Group Number	ID Number
Policy Holders Name	DOB: MM/DD/YYYY	Social Security Number of Policy Holder
Secondary Insurance Company Name	Group Number	ID Number
Policy Holders Name		

Emergency Information			
Person to notify in case of an emergency	Relationship	Cell Phone	Home Phone
Person to notify in case of an emergency	Relationship	Cell Phone	Home Phone