Launch Registration Form

Child's Full Name:_____ Preferred Name:_____

DOB:_____ Age:_____ Sex: ☐ M ☐ F SS#_____-_____-_____

Address:_____Apt/Lot:_____

City:_____ State: _____ Zip:_____

Mother/Guardian Name: _____

Are you the legal guardian? ☐ YES ☐ NO Are you authorized to make medical decisions for the patient? ☐ YES ☐ NO

Daytime Phone:_____ Cell Phone:_____

Father/Guardian Name: _____

Are you the legal guardian? ☐ YES ☐ NO Are you authorized to make medical decisions for the patient? ☐ YES ☐ NO

Daytime Phone:_____ Cell Phone:_____

Email Address:_____

Doctor's Name:_____ Doctor's Phone:_____

INSURANCE/BILLING INFORMATION –***We will need to copy all insurance cards & a photo ID.***

Primary Insurance:_____

Subscriber's Name:_____ DOB:_____ SS#:_____-_____-_____

Member/Subscriber ID:_____ Group #:_____

Relationship to Subscriber: ☐ SELF ☐ CHILD ☐ OTHER Employer: _____

Secondary Insurance (if applicable): _____

Subscriber's Name:_____ DOB:_____ SS#:_____-_____-_____

Member/Subscriber ID:_____ Group #:_____

Relationship to Subscriber: ☐ SELF ☐ CHILD ☐ OTHER Employer: _____

IN CASE OF EMERGENCY

Name: _____Phone:_____ Relationship to child:_____
Name: _____Phone:_____ Relationship to child:_____

******ALLERGIES/DIETARY RESTRICTIONS******

Allergen: _____ Reaction:_____

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Dietary restrictions: _____