ARKANSAS
FAMILIES FIRST

Child/Adolescent Patient Registration

Patient:____
(Last) (First) (MI)
Social Security Number:_________________________________ Date of birth_____________________________
Address:____
(Street) (City) (State) (Zip)

Primary Contact Phone:____(Is this a cell phone number?__Yes __No)

Male__ Female__ School Grade:______ Race:________________Ethnicity:_________________

Would you like to enroll in the Patient Portal to receive:
Email reminders?___Yes___No Preferred Email Address: ____
Test message reminders?___ Yes ___No Preferred Cell #: __________________ Carrier: ________________

Patient's Primary Care Physician:_______________________________Phone:___________________________
Referred By:____Phone:___________________________
Preferred Pharmacy (name/address/phone):____
Mother's Name:____Biological-Step-Adoptive-Guardian (Circle)
Mother's Address:____
Primary Phone:___________________________________ Work Phone:_________________________________
Social Security Number________________________________ Date of Birth:______________________________

Father's Name:____Biological-Step-Adoptive-Guardian (Circle)
Father's Address:____
Primary Phone:___________________________________ Work Phone:_________________________________
Social Security Number:_______________________________ Date of Birth:______________________________

Emergency Contact:_______________________Relationship:___________________Phone:________________

Please Provide Insurance Cards and Parent/Guardian Driver's License to our staff
Primary Insurance _____________________________________Phone_________________________________
Address____
Name of policy holder____Date of Birth________________________
Identification number________________________________Group number_____________________________
Secondary Insurance____________________________________Phone_________________________________
Address____
Name of policy holder____Date of Birth________________________
Identification number____________________________________Group number_________________________