CTC Registration Sheet

Please complete the following information so that we may register your child with the hospital.

PATIENT DATA					
LAST NAME	**FIRST NAME**	**M.I.**	**MAIDEN NAME** NOT APPLICABLE		
SOCIAL SECURITY NUMBER	**PHONE** **Home-** **Work-** **Cell-**	**BIRTHDATE**	**SEX**	**MARITAL STATUS** Single	**RACE**
STREET		**CITY, STATE, ZIP**			
RESIDENCE (COUNTY, CITY, TWP OR BOROUGH)		**PLACE OF BIRTH**			
SCHOOL		**GRADE**			
Diagnosis (if known)		**Any pain ? Y N**			

RELATIVE'S CONTACT DATA		
MOTHER'S FULL NAME	**MOTHER'S ADDRESS**	**MOTHER'S PHONE** **Home** **Work** **Cell**
FATHER'S FULL NAME	**FATHER'S ADDRESS**	**FATHER'S PHONE** **Home** **Work** **Cell**
EMERGENCY CONTACT PERSON	**RELATION TO CHILD**	**CONTACT'S PHONE**
EMERGENCY CONTACT PERSON	**RELATION TO CHILD**	**CONTACT'S PHONE**
PERSON(S) TO WHOM CHILD MAY BE RELEASED	**NAME/ADDRESS**	**PHONE**
PERSON(S) TO WHOM CHILD MAY BE RELEASED	**NAME/ADDRESS**	**PHONE**

Guarantor Information

The Guarantor is the person with whom the insurance policy is held. (i.e. mother, father or guardian) An employer usually provides this policy. If the patient has Medical Assistance as a primary insurance please provide information below for either parent/guardian.

	GUARANTOR DATA		
GUARANTOR NAME	**BIRTHDATE**		**GUARANTOR PHONE** **Home** **Cell**
GUARANTOR SS#	**GUARANTOR ADDRESS**		
GUARANTOR EMPLOYER AND PHONE NUMBER	**GUARANTOR EMPLOYER'S ADDRESS**		**GUARANTOR'S OCCUPATION**

		INSURANCE DATA		
1.	**NAME OF INSURANCE**	**SUBSCRIBER**	**RELATION TO PT.**	**EFFECTIVE DATE**
		I.D. NUMBER	**GROUP NUMBER**	
2.	**NAME OF INSURANCE**	**SUBSCRIBER**	**RELATION TO PT.**	**EFFECTIVE DATE**
		I.D. NUMBER	**GROUP NUMBER**	
3.	**NAME OF INSURANCE**	**SUBSCRIBER**	**RELATION TO PT.**	**EFFECTIVE DATE**
		I.D. NUMBER	**GROUP NUMBER**	

VITAL DATA
ALLERGIES - Please list below **Medications** **Dietary** **Environmental** **Latex**
SPECIAL DISABILITIES:
MEDICAL OR DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATIONS:
MEDICATION, SPECIAL CONDITIONS:
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD:

REFERRING PHYSICIAN AND PHONE NUMBER	
FAMILY PHYSICIAN AND PHONE NUMBER	
CONFIDENTIAL PATIENT	**CHURCH/HOSPITAL CLERGY NOTIFIED?**
PARENT SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT	
Obtaining Emergency Medical Care **X**	**Administration of Minor First Aid Procedures** **X**

The hospital has a policy for releasing information about a patient in the absence of a parent/guardian. You are asked to choose a password that is no more than 10 letters or numbers. As long as they know the password, we will share information with any caregiver that may bring your child for services. If the caregiver does not know the password we cannot share any information regarding your child with them. You can change your password at any time with the front office staff.

Password: _____

_____ _____

(Signature Parent/Guardian) (Date)

PERIOD REVIEW:

(Update) _____ _____

(Signature Parent/Guardian) (Date)

(Update) _____ _____

(Signature Parent/Guardian) (Date)