FAMILY REGISTRATION FORM (Please print clearly)	
Parent/Guardian name (First and Last)	**Parent/Guardian name (First and Last)**
Address	Address (if different)
City, State, Zip	City, State, Zip
Primary Phone	Primary Phone
Email Address	Email Address
Preferred Phone Number to use for appointment information and messages	Preferred Phone Number to use for appointment information and messages
Employer	Employer
Date of Birth	Date of Birth

LIST CHILDREN BY BIRTH DATE, OLDEST FIRST

Name	Sex	Birthdate	Child's cell # (If applicable)	Legal Guardian (If applicable)
1)				
2)				
3)				
4)				
5)				

Insurance Company:	**Insured's Name:**
Preferred pharmacy and phone number:	

INDIANA LAW REGARDING REFERRALS

A new Indiana law effective January 2018 requires referring physicians to provide patients with a written notice of the following:

(1) That an out-of-network provider may be called upon to render health care items or services to the covered individual during treatment.

(2) That an out-of-network provider is not bound by the payment provisions that apply to health care items or services rendered by a network provider under the covered individual's health plan.

(3) That the covered individual may contact the covered individual's health plan before receiving health care items or services rendered by an out-of-network provider.

a. To obtain a list of network providers that may render the health care items or services and for additional assistance.

I understand the above information regarding referrals.

Parents Signature _____ Date _____

Initials	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PLEASE CONTINUE TO THE OTHER SIDE