# VIP MidSouth, LLC
# Registration Form

**Today's Date:** **Patient Account # (office use only):**

## Patient Information

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Patient Last Name:** | | | **First:** | | **Middle:** | | | **I prefer to be called:** | |
| **Date of Birth:** | | **Gender:** | **Male** **Female** | | **SS#:** | | **Primary Language(required):** | | |
| **Race: (Choose One)** | **American Indian/Alaskan** | **Asian** **Declined** | **African American/Black** | **Native Hawaiian/Pacific Islander** | **White** **Other** | **Ethnicity: (Choose One)** | **Hispanic/Latino** **Not Hispanic/Latino** | **Declined** **Unknown** | |
| **Address:** | | | **City:** | | | | **State:** | **Zip:** | |
| **Home Phone:** | | | **Work Phone:** | | | **Cell Phone:** | | | |
| **Primary Pharmacy:** | | **Email Address:** | | | **Place of Birth (hospital):** | | **Name at Birth:** | | |

## Mother's Information

| | | | | |
|---|---|---|---|---|
| **Name:** | | | **Date of Birth:** | **SS#:** |
| **Address: (If different than patient)** | **City:** | | **State:** | **Zip:** |
| **Home Phone:** | **Work Phone:** | | | **Cell Phone:** |
| **Employer:** | **Are you the insurance carrier:** | **Yes** **No** | | **If yes is coverage:** **Primary** **Secondary** |
| **Insurance Name:** | **Insurance Effective Date:** | | **Should you receive the statement for this account:** | **Yes** **No** |

## Father's Information

| | | | | |
|---|---|---|---|---|
| **Name:** | | | **Date of Birth:** | **SS#:** |
| **Address: (If different than patient)** | **City:** | | **State:** | **Zip:** |
| **Home Phone:** | **Work Phone:** | | | **Cell Phone:** |
| **Employer:** | **Are you the insurance carrier:** | **Yes** **No** | | **If yes is coverage:** **Primary** **Secondary** |
| **Insurance Name:** | **Insurance Effective Date:** | | **Should you receive the statement for this account:** | **Yes** **No** |

## Emergency Contacts

| | | |
|---|---|---|
| **Name:** | **Phone #:** | **Relationship to patient:** |
| **Name:** | **Phone #:** | **Relationship to Patient:** |

## Patient's Siblings

| | | |
|---|---|---|
| **Name:** | **DOB:** | **Are they a current patient?** |
| **Name:** | **DOB:** | **Are they a current patient?** |

## Consent for Treatment

**This certifies that I, the parent/legal guardian, request treatment of our minor child by the physicians and/or staff of VIP MidSouth, LLC. Authorization is hereby granted for such treatment.**

**Parent/Legal Guardian Signature:** _____ **Witness Signature:** _____

**Date:** _____