UCI CHILD DEVELOPMENT CENTER
Confidential Patient Registration Form

Patient's (Child) name____Date of Birth________/_______/______

Address____City__________________Zip_____________

Child's Social Security #______________________________School District_______________________________

Last School Attended_____________________________________Grade Level______________________________

Mother's name____Date of Birth_______/_______/________

Street address (if different from patient's)____

City_______________________________________Zip______________Home phone (   )___________________

Cell phone (   )_______________________________Social Security # __________________________________

E-mail address____

Employer____________________________Occup._________________Work phone (   ) __________________

Employer address_________________________________City____________________Zip___________________

Father's name____Date of Birth_______/_______/__________

Street address (if different from patient's)____

City_______________________________________Zip______________Home phone (   )___________________

Cell phone (   )_______________________________Social Security # __________________________________

E-mail address____

Employer____________________________Occup._________________Work phone (   )__________________

Employer address_________________________________City____________________Zip___________________

Emergency contact's name_________________________________Relationship to patient___________________

Street address________________________________City___________________________Zip_______________

Home phone (   )______________________________ Work phone (   )___________________________________

Cell phone (   )_______________________________ E-mail address_________________________________

Emergency contact's name_________________________________Relationship to patient___________________

Street address________________________________City___________________________Zip_______________

Home phone (   )______________________________ Work phone (   )___________________________________

Cell phone (   )_______________________________ E-mail address_________________________________

Authorization: I understand that I am personally responsible for all charges. In the event that I seek insurance reimbursement, and the UCI Child Development Center is contacted for verification of services, I authorize the UCI Child Development Center to provide necessary information requested by my insurance carrier. A copy of this authorization shall be considered as valid as the original.

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Signature of responsible party   Date