



Pediatric Patient Registration

Child's name _____ Sex M F Date of birth ____/____/____
First MI Last MM DD YYYY

Name patient prefers to be called _____

Address _____
Street City State Zip

Person completing this form _____

Parent/Guardian (A) name _____ Date of birth ____/____/____
First MI Last MM DD YYYY

Relationship to child Biological parent Adoptive Step Other (describe) _____

Parent/Guardian (B) name _____ Date of birth ____/____/____
First MI Last MM DD YYYY

Relationship to child Biological parent Adoptive Step Other (describe) _____

Address _____

Telephone _____ Cell Landline Email _____

Primary language _____ Other languages spoken around the child _____

Child's physician and clinic name _____ Phone _____

Who should be our primary contact for this child? _____

What is the best way to receive appointment reminders? (check one) Text Email Phone call

If parents are living apart, the child mainly lives with:

Who has custody of your child?

List everyone who lives in the home _____

List everyone who should receive a copy of today's report _____

PLEASE READ, CHECK THE BOXES AND SIGN BELOW

I agree I am ultimately responsible for the balance of my account for services rendered.

I agree to the Notice of Privacy Information Practices, which describes how my health information may be used and disclosed. It was made available to me either in the office or at NelsonHearing.com.

I have read the information on this form and certify this information to be true and correct to the best of my knowledge. I agree to the checked boxes above and give Nelson Hearing Clinics permission to treat my concerns.

Guardian signature _____

Today's date _____

Fairmont, MN
400 N. State St.
Fairmont, MN 56031
P: (507) 235-5323
F: (507) 235-6126

Spencer, IA
119 E. 5th St.
Spencer, IA 51301
P: (712) 262-7774
F: (712) 262-6758

Le Mars, IA
116 Central Ave NE
Le Mars, IA 51031
P: (712) 546-4723
F: (712) 560-7421

Sheldon, IA
712 4th Ave.
Sheldon, IA 51201
P: (712) 546-4723
F: (712) 560-7421