



Patient Registration Sheet

Gayatri K. Shanker MD FAAP
Shelley Ridgway FNP-BC
Shelley L. Sibbold CPNP-PC
Ashley Taylor FNP-BC

Ph. 989-793-1095

4684 Wenmar Dr., Saginaw, MI 48604

Child's Name:		Date of Birth:		Mother's Maiden Name:	
Address:		City:		St:	Zip: Sex:
For Patient Portal - Primary Parent Email Address:				Language:	
RACE: (Please check the appropriate box)					
<input type="checkbox"/> AMERICAN INDIAN / ALASKA NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK/AFRICAN AMERICAN <input type="checkbox"/> NATIVE HAWAIIAN <input type="checkbox"/> OTHER PACIFIC ISLANDER <input type="checkbox"/> WHITE <input type="checkbox"/> MORE THAN ONE RACE <input type="checkbox"/> REFUSED TO REPORT					
ETHNICITY: (Please check the appropriate box)					
<input type="checkbox"/> HISPANIC / LATIN AMERICAN <input type="checkbox"/> NON-HISPANIC / LATIN AMERICAN <input type="checkbox"/> REFUSED TO REPORT					
Parent/Responsible Party:			Sex:		Date of Birth:
Address:			City:		St: Zip:
Soc. Sec.#:		Home Ph.:		Cell: Work:	
Employer:			Occupation:		
Employer Address:			City:		St: Zip:
Other Parent Name:			Sex:		Date of Birth:
Address:			City:		St: Zip:
Soc. Sec.#:		Home Ph.:		Cell: Work:	
Employer:			Occupation:		
Employer Address:			City:		St: Zip:
Emergency Contact Name: (Outside the household) :					
Home Ph.:		Cell Ph.:		Relationship:	
HEALTH INSURANCE INFORMATION					
PRIMARY INSURANCE			SECONDARY INSURANCE		
Carrier Name:			Carrier Name:		
Subscriber Name:			Subscriber Name:		
Date of Birth:			Date of Birth:		
Policy ID:			Policy ID:		
Group #:			Group #:		
Co-Pay:			Co-Pay:		
Relation to Patient:			Relation to Patient:		

This form was completed correctly to the best of my knowledge. Please inform the office of any changes.

 Signature of Parent or Responsible Party

 Relationship to the Patient

 Date