Patient Registration

Is this your first visit at this office? ☐ Yes ☐ No **Today's Date:** ___________

Patient Information

Name: ____

Date of Birth: ______________________________ Sex: ☐ M ☐ F

Home Address: ___________________________________

City: _____________________ State: _________ Zip: _________

Sibling Names and Ages *(ex: Jack, 9)*: _______________________
____

Parent/Guardian Information

PRIMARY FAMILY EMAIL: ___________________________________

PRIMARY FAMILY PHONE: (_____)__________________ (*OFFICE USE: LABEL AS "MAIN"*)

Parent Name: ________________________ Date of Birth: _________

Mobile Phone: (_____)___________ **Work Phone:** (____)__________

Home Address (*if different from child*): ___________________________

City: _____________________ State: _________ Zip: _________

Employer: ____

Parent Name: ________________________ Date of Birth: _________

Mobile Phone: (_____)___________ **Work Phone:** (____)__________

Home Address (*if different from child*): ___________________________

City: _____________________ State: _________ Zip: _________

Employer: ____

Alternate Contact (relative or friend): _________________________

Alternate Contact Phone: (_____)________________________________

Relationship to patient: ___________________________________

We are required to collect the following information for each patient. Please complete this section before returning the form. Thank you.

Preferred Doctor/ARNP:
____

Your Preferred Language:
____

Your Child's Race/Ethnicity
(select one primary)

- ☐ American Indian
- ☐ Asian
- ☐ Black/African American
- ☐ Caucasian
- ☐ Hispanic
- ☐ Multiracial
- ☐ Unknown
- ☐ Other ______________
- ☐ Decline to answer

Insurance Information

Insurance Plan: ______________________________________ Effective Date: ___________________

Name of Policy Holder: _______________________________ Date of Birth: ______________ Sex: ☐ M ☐ F

I understand that payment of all medical care is due at the time of service. The parent and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Pediatric Health Care Alliance, P.A. to release any pertinent information to my insurance company upon request, and I also authorize payment directly to Pediatric Health Care Alliance, P.A.

A photocopy of this authorization shall be considered as effective and valid as the original.

_________________________ _________________________ _________________
Billing Guarantor Name *(print)* **Signature** **Date**

(______) - _________________ _________________________ **Sex:** ☐ **M** ☐ **F**
Billing Guarantor Primary Phone **Social Security #**

***** Return this form to a staff member before leaving the office. Thank you. *****