

2010

Patient Registration



Pediatric Health Care Alliance, P.A.

Your Child's Medical Home™

PATIENT INFORMATION

Date: _____ How did you **first** hear about us? _____

Patient Name: _____ Date of Birth: _____ Sex: M F

Relationship to Guarantor: _____ Social Security Number: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____ Home Telephone: (____) _____

Next of Kin (not living at address listed above): _____ Relationship: _____

Address: _____

Siblings who visit this office:	Name	Sex (M/F)	DOB (mm/dd/yy)	Social Security #
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

PARENT INFORMATION

Marital Status of Parents: Married Divorced or Divorce Pending Single (never married)

Mother's Name: _____ Date of Birth: _____ SS #: _____

Contact E-Mail Address: _____ (You will receive periodic email newsletters)

Home Address (if different from child): _____

City: _____ State: _____ Zip Code: _____ Home Phone: (____) _____

Employer: _____ Work Phone: (____) _____ Cell Phone: (____) _____

Father's Name: _____ Date of Birth: _____ SS #: _____

Contact E-Mail Address: _____ (You will receive periodic email newsletters)

Home Address (if different from child): _____

City: _____ State: _____ Zip Code: _____ Home Phone: (____) _____

Employer: _____ Work Phone: (____) _____ Cell Phone: (____) _____

INSURANCE INFORMATION

Primary Insurance Name: _____ Effective Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Full Name of Insured: _____ Date of Birth: _____ SS#: _____

Employer: _____ Policy Type: HMO PPO PPC Other: _____

ID Number: _____ Group Number: _____ Co-Pay Amount: _____

If you belong to an HMO, do you also have other Group Insurance Coverage? Yes No

Preferred Pharmacy Name: _____ Location/Phone: _____

Previous Physician: _____

IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Phone: (____) _____

Name: _____ Relationship: _____ Phone: (____) _____

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.

Parent Guardian Signature _____ Date _____ Witness Signature _____ Date _____

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