Patient Registration Form

Pediatric Health Care Alliance, P.A.
Your Child's Medical Home™

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

FORM COMPLETED BY:

_____	_____	_____
Name *(print)*	**Signature**	**Date**

***** Return this form to the Front Desk before leaving the office. Thank you. *****