

# Patient Registration Form 18 & Older or Foster Parent



Pediatric Health Care Alliance, PA.

Your Child's Medical Home™

Today's Date: \_\_\_\_\_

*Please confirm your contact information is correct. We use this information to contact you about appointments, alerts, general health information, PHCA news and services, as well as payments and billing matters.*

## Patient Information

Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Sex:  M  F  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Mobile phone: \_\_\_\_\_ Email: \_\_\_\_\_

## Parent/ Foster Parent Information

Parent Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Mobile Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

## Insurance Carrier Information

Insured's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Name of Insurance: \_\_\_\_\_  
Home Address (if different from patient): \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Alternate Contact (relative or friend)

Alternate Contact Phone: ( ) \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_

## Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how protected health information will be used and disclosed. I understand that Pediatric Health Care Alliance, PA has the right to change its Notice of Privacy Practices that will be effective for health information the practice already has about me or my child(ren), as well as any they receive in the future. PHCA will post a current copy of the Notice. I understand I may receive a copy of the current Notice of upon request.

I have read all of the above information and understand/ agree to all provisions therein regarding financial responsibility, permission for treatment and Notice of Privacy Practices.

Name (print): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**We are required to collect the following information for each patient.**

**Please complete this section before returning the form. Thank you.**

**Preferred Doctor/ARNP:**  
\_\_\_\_\_

**Preferred Language:**  
\_\_\_\_\_

### Your Race

*(select one primary)*

- American Indian or Alaska Native
- Asian
- Black/African American
- Chinese
- Filipino
- Hispanic
- Japanese
- Multiracial
- Native Hawaiian or Other Pacific Islander
- White
- Unknown
- Other \_\_\_\_\_
- Decline to answer

### Your Ethnicity

- Hispanic or Latino
- Non-Hispanic or Latino
- Unknown
- Declined to answer

\*\* Please return this form to the Front Desk before leaving the office. Thank you. \*\*