

Patient Registration Form



Pediatric Health Care Alliance, PA.

Your Child's Medical Home™

Today's Date: _____

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: _____

Form Completed By:

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 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.

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