The ChildHealth Center, PA

Patient Registration

Patient's Full Legal Name:_____ Date of Birth:_____/_____/_____ Gender: _____

SS#:_____ Home Phone: _____ Email:_____

Mailing Address: _____Preferred Method of Contact : Phone____ Mail___

Insurance Carrier:_____ Medicaid? Y N Person responsible for payment:_____

Government regulations require that we gather the following information for each of our patients:

Race: ___Asian ___Native Hawaiian ___Other Pacific Islander ___Black/African American (not Hispanic or Latino)

___American Indian/Alaska Native ___ White (not Hispanic or Latino)____ Hispanic or Latino (all races)

Language: _____ **Ethnicity:** ___Hispanic or Latino ___Not Hispanic or Latino

Father's Name:_____ Date of Birth:____/____/____ Marital Status: _____

SS#:_____ Home #:_____ Cell #: _____ Work #: _____

Address (if different): _____

Employer: _____ Position: _____ Are calls allowed? Y N

Education (Highest level completed):_____ Religion (optional): _____

Mother's Name:_____ Date of Birth:_____/_____/_____ Marital Status: _____

SS#:_____ Home #:_____ Cell #: _____ Work #: _____

Address (if different): _____

Employer: _____ Position: _____ Are calls allowed? Y N

Education (Highest level completed):_____ Religion (optional): _____

Legal Guardian:_____ Date of Birth:_____/_____/_____ Marital Status: _____

SS#:_____ Home #:_____ Cell #: _____ Work #: _____

Address (if different): _____

Employer: _____ Position: _____ Are calls allowed? Y N

List brothers/sisters of the patient: _____ Who referred you to The ChildHealth Center?_____

List two alternate contacts not living with you that we may contact in the event that we cannot reach you.

Name:_____ Phone:_____

Name: _____ Phone:_____

I give permission for the physicians of The ChildHealth Center, PA to interview, examine, perform necessary tests, and provide appropriate treatment to the above named minor. Permission for evaluation and treatment is granted whether the child is presented by the parent, other family member, unrelated person, or unaccompanied. In addition, I authorize The ChildHealth Center, PA to provide my insurance company any necessary information related to services rendered to my child (if over 18, myself). I also authorize my insurance company to pay the amount due for services rendered directly to The ChildHealth Center, PA. I understand that *I am ultimately responsible* for the payment of all charges resulting from services provided. I also understand that it is my responsibility to provide The ChildHealth Center, PA with up-to-date insurance and/or demographic information.

Signed _____ Relationship_____ Date_____

I have read and understand The ChildHealth Center, PA HIPPA Policy, my NCHIE notification, Scheduling Policies and Procedures regarding hours of operation, extended office hours, after hour calls, phone nurses, along with scheduling sick and well visits in conjunction with The ChildHealth Center, PA missed appointment policy.

Signed_____ Relationship_____ Date_____